KERN COUNTY
CHILDREN AND FAMILIES COMMISSION

STRATEGIC PLAN FOR EARLY CHILDHOOD DEVELOPMENT IN KERN COUNTY

FEBRUARY 23, 2000

A child derives strength from the family and the family derives strength from the community. Proposition 10 has offered a great opportunity for the community to work together to improve services for families and young children. The Kern County Children and Families Commission welcomes the interest and support of individuals, groups and organizations into this exciting new process.

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I. INTRODUCTION

This Strategic Plan describes a vision for a comprehensive system to support early childhood development in Kern County, and the means to assist in making that vision a reality. The following sections will describe how this Strategic Plan is being developed, will discuss Kern County's unique service needs and requirements, and will suggest ways in which the resources available through the Children and Families Trust Fund may be used to support programs and services to meet those needs and requirements.

Proposition 10 requires that each county commission:
"Adopt an adequate and complete county strategic plan for the support and improvement of early childhood development within the county. The strategic plan must include a description of the goals and objectives proposed to be attained; a description of the programs, services and projects proposed to be provided, sponsored, or facilitated; and a description of how measurable outcomes of such programs, services, and projects will be determined by the county commission using appropriate reliable indicators."

This plan is the current product of the work and input of scores of parents, advocates, educators and professionals from throughout the County. It is based on the best available research and represents the current synthesis of our thinking on how to best use the resources generated by Proposition 10 to create long-term positive outcomes for young children and their families in Kern County. We consider this a work-in-progress that will evolve over time. The strategic planning process is ongoing and our plan will be refined and expanded throughout the years so that we can make our best efforts to respond to the ever-changing needs of our communities.

II. THE FOUNDATION

The foundation of any good plan must be solidly constructed in a deliberate and inclusive manner. The Kern County Children and Families Commission and the Technical Advisory Committee worked diligently to develop a Vision Statement and a Mission Statement, which are patterned on the State model, but reflect their common view from the local perspective.

The Vision Statement is a broad statement designed to convey the Commission's vision of the ideal condition of the children of Kern County prenatal to 5 years old and their families. The Vision Statement attempts to communicate the intended end result of our efforts and declare the reason for our existence. It derives from the human need to envision the future. The Strategic Plan is built upon the foundation of this vision.

The Mission Statement describes in general terms what the Commission intends to accomplish. The Mission Statement is centered on the process of what we need to be doing and what it is that we want to achieve. Its language suggests priorities and discusses the task with which we are charged.

The Guiding Principles describe with more clarity of detail the environment in which the Commission will operate and the rules to which it will adhere in supporting and sponsoring programs and services.

Goals and objectives will necessarily flow from these three elements. A detailed description of these goals and objectives are specifically articulated in Section IV, Strategies and Outcomes.

VISION STATEMENT

Through collaboration and the integration of services, all Kern County children are born and thrive in supportive, safe and loving homes and neighborhoods. They enter school healthy and ready to learn, and become productive, well-adjusted members of society.

MISSION STATEMENT

Current research in brain development indicates that the emotional, physical and intellectual environment to which a child is exposed in the earliest years of life has a profound impact on how the brain is organized. The relationships and contacts a child has with parents and caregivers significantly influences how a child will function in school and later in life.

The California Children and Families Act is designed to provide, on a community-by-community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services. Through the integration of health care, quality child care, parent education, and effective intervention for families at risk, children and their parents and caregivers will be provided with the tools necessary to foster secure, healthy, and loving attachments. These attachments will lay the emotional, physical, and intellectual foundation for every child to enter school ready to learn and develop the potential to become productive, well-adjusted members of society. Children and family services are best integrated and delivered through community collaboration. Therefore, it is critical that community collaboration be developed and sustained throughout Kern County.

GUIDING PRINCIPLES

First Principles

- We will support programs and services for all children prenatal to 5 years of age and for their families.
- We believe that the role of parents and guardians is paramount to the success of our efforts.
- We will treat others with honesty and respect, and will consistently demonstrate these values and principles in our actions.
- We will support programs and services that affirmatively demonstrate a shared respect and acceptance of our principles.
- We will work deliberately, but with a sense of urgency, to implement our plans, programs and services, recognizing that time is of the essence.

Inclusiveness and Collaboration

- We will respect the cultural diversity among us by providing outreach to all communities, including families with special needs.
- We will encourage collaboration where it is appropriate, including cooperation between agencies and the involvement of existing collaborative networks and partnerships.

Community Involvement

- We will place an emphasis upon the assets and resources available in the community, rather than upon the needs and deficits existing in the community.
- We will support efforts to mobilize the community around critical issues affecting young children and their families.

Integration of Services

- We will support efforts to develop comprehensive service delivery where services and projects are integrated into easily accessible child and family-centered systems.
- We will encourage and support the development of each community's capacity to provide integrated services.
- We will support programs that provide high quality, outcomes-based integrated services to families.

Planning Process

- We will engage in an ongoing, dynamic and evolving strategic planning process to meet the changing needs of all communities.

- We will build upon existing resources and research during strategic plan development and program sponsorship.

- We will seek feedback and expertise from a diverse population of health and education professionals, parents and the early childhood and tobacco education communities.

- We will encourage and support community participation in the planning process, recognizing our ethnic, cultural, income and geographic diversity.

Innovation and the Use of Scientific Research

- We will support programs and services that demonstrate innovation in program design and service delivery.

- We will support programs and services that utilize appropriate scientific findings and best practices as the foundation for their program designs.

- We will consider research findings in selecting the most effective programs and strategies.

Measurable Effectiveness

- We will support program designs that identify sustainable, positive and measurable outcomes simply, effectively and in a way that can be clearly communicated.

- We will promote the achievement of positive outcomes for children and their families by evaluating program impacts on children and families.

Administration, Fiscal Responsibility and Accountability

- We will expend the funds entrusted to us appropriately and efficiently, maximizing funding for programs and services and minimizing expenditures for administrative purposes.

- We will conduct our business in an open, accountable and professional manner.

- We will implement long-range financial planning based on the expectation that Proposition 10 allocations will become a dwindling revenue source.

- We will support the use of multiple funding sources, such as leveraging and matching grant funds from other private, local, state or federal programs, for programs and services.

III. THE PLANNING PROCESS

PROPOSITION 10 – STATE IMPLEMENTATION

Proposition 10 was enacted by the voters of California on November 10, 1998 and the Legislature codified the Proposition as the California Children and Families Act of 1998. This initiative added a $.50 per pack tax on cigarettes, added an equivalent tax increase on distributed tobacco products and created a trust fund for the revenues collected. A total of eighty percent of the funds collected statewide are to be distributed to counties, to be used exclusively for the purpose of promoting, supporting and improving the early development of children from the prenatal stage to five years of age. Revenues will be used for the following:

- To create a comprehensive and integrated delivery system of information and services to promote early childhood development
- Provide funds to existing community based centers or establish new centers that focus on parenting education, child health and wellness, early child care and education, and family support services
- Educate Californians via a statewide multimedia campaign on the importance of early childhood development
- Provide assistance to pregnant women and parents of young children who want to quit smoking

Young children are all too often affected by some of our society's most serious problems. To have *real* impact on these problems, we must invest in our children during the first five years - starting before they are born.

Since January 1999 special taxes from the sale of tobacco products have been accumulated into a designated trust fund to meet the needs of children ages prenatal to 5 throughout the State. Eighty percent of these funds are disseminated to the 58 counties of the State according to the live birth rate of each county. The remaining twenty percent will be directed to statewide programs and research.

PROPOSITION 10 – LOCAL IMPLEMENTATION

The Kern County Board of Supervisors assigned initial responsibility to the County Administrative Office to make a recommendation regarding the participation of Kern County in the Proposition 10 program. On December 15, 1998, the Kern County Board of Supervisors enacted a local Ordinance that established the Kern County Children and Families Commission and Trust Fund. Commissioners were appointed in accordance with the law and are now as follows:

Permanent Appointments	**Terms ending 3/ 31/ 2000**	**Terms ending 3/31/2001**
Pete H. Parra, 5th District Supervisor, Member of the Board of Supervisors	**Christine A. Hoffman,Ed.D.,** Local School District representative (appointed by Supervisor Perez)	**Martin Castro,** Community-based organization with goal of promoting nurturing and early childhood development (appointed by Supervisor Parra)
Babatunde A. Jinadu, M.D., M.P.H., County Health Officer	**Linda Low,** Local organization for prevention or early intervention for families at risk (appointed by Supervisor Patrick)	**Leslie M. Dragoo,** Educator specializing in early childhood development (appointed by Supervisor Peterson)
Kathleen M. Irvine, Director of Human Services:		**Victoria Schauf, M.D.,** Local medical, pediatric or obstetric association member (appointed by Supervisor McQuiston)
Diane Koditek, M.F.C.C., Director of Mental Health Department		

Kern County Children and Families Commission Activities

The Kern County Children and Families Commission first met on May 26, 1999, in Bakersfield, California, and conducted subsequent meetings as follows:

June 23, 1999, Bakersfield	July 21, 1999, Bakersfield
August 11, 1999, Bakersfield	August 25, 1999,Ridgecrest
September 8, 1999, Taft	September 22, 1999, Delano
October 6, 1999, Mojave	October 20, 1999, Frazier Park
November 3, 1999, Bakersfield	November 17, 1999, Lamont
December 22, 1999, Oildale	January 12, 2000, Wasco

At its first meeting on May 26, 1999, the Commission adopted By-Laws, adopted a Conflict of Interest Policy. At its meeting of June 23, 1999, the Commission created a Technical Advisory Committee consisting of three Commissioners and 18 community members. Commissioners Jinadu, Dragoo and Castro sit on the Technical Advisory Committee. The community members of the TAC and their working affiliations are as follows:

Scott Allen, Clinica Sierra Vista (appointed by Commissioner Hoffman)	**Deanna Cloud,** Kern County Mental Health Department (appointed by Commissioner Koditek)
Art Armendariz, City of Delano, Councilperson (appointed by Commissioner Schauf)	**Dr. John Digges,** Jameson Center (appointed by Commissioner Irvine)
Jesse Atondo, Lamont School District, Board member (appointed by Commissioner Parra)	**Nancy Frick**, Lamont/Weedpatch Neighborhood Partnership (appointed by Commissioner Low)
Mary Barlow, Kern River Valley Collaborative (appointed by Commissioner Schauf)	**Kris Grasty**, Kern County Department of Human Services (appointed by Commissioner Irvine)
Irma Carson, Ebony Counseling Center , (appointed by Commissioner Parra)	**Bill Phelps**, Clinic Sierra Vista (appointed by Commissioner Dragoo)
Estella Casas, Greater Bakersfield Legal Assistance (appointed by Commissioner Castro)	**Steve Sanders**, Kern County Network for Children (appointed by Commissioner Low)
Anne Cervantes, Blue Cross of California (appointed by Commissioner Castro)	**Cindy Wasson**, Kern County Department of Public Health (appointed by Commissioner Jinadu)
Judy Chapman, Kern County Superintendent of Schools (appointed by Commissioner Hoffman)	**Wendy Wayne**, Kern County Superintendent of Schools (appointed by Commissioner Dragoo)
Dr. Portia Choi, Kern County Department of Public Health (appointed by Commissioner Jinadu	**Allene Zanger,** Kern County Superintendent of Schools (appointed by Commissioner Koditek)

On July 21, 1999, the Commission adopted a budget for fiscal year 1999-2000 and approved an agreement with the County to provide administrative, legal, fiscal and insurance services.

Along with the initial actions taken to establish and organize the organization, the Commission took steps to begin development of a comprehensive strategic plan, which would identify the diversity of needs and suggest actions and policies to improve early childhood development services throughout the County. This is an important task that must be done well, for once complete, it provides the blueprint in setting priorities for programs, services and support. Comprehensive data has been and continues to be collected on child care, early childhood education, child health and wellness, and family support and education. Additionally, work is continuing in the various communities throughout the County to provide all citizens an opportunity for input on how to support and integrate services to meet a diversity of needs.

At its meeting of September 22, 1999, the Commission adopted its Mission and Vision Statement. On September 23, 1999, the Commission issued its Report of Implementation and Performance and Fiscal Audit and sent it to the State Children and Families Commission in accordance with the requirements of the law. On October 6, 1999, the Commission hired Steven G. Ladd as its Executive Director. Soon thereafter a timeline for drafting the Strategic Plan was developed. This timeline calls for adoption of the Strategic Plan by the Commission in February of 2000 and the beginning of the funding allocation and distribution process in the spring of 2000.

During November and December of 1999, eight community meetings were held to provide the public opportunities to both learn about the strategic planning process and to provide input to the planning process. Meetings were conducted as follows:

November 1, 1999	McFarland
November 2, 1999	Lake Isabella
November 8, 1999	Arvin
November 15, 1999	Shafter
November 16, 1999	Rosamond
November 22, 1999	Tehachapi
November 23, 1999	Oildale
December 7, 1999	Delano

On December 9, 1999, the Commission held a Strategic Planning Workshop, which was facilitated by Steve Barrow, Director of the Results Strategies & Advocacy Institute. The workshop provided hands-on technical assistance to those individuals who have been actively

involved in drafting our strategic plan. Using the work produced by the Technical Advisory Committee, participants developed a list of issues, program areas and integration concepts to focus on if Kern County wants to "turn the curve" on young children's health over the next 3 to 5 years. The workshop participants then prioritized, via a voting process, their "turning the curve" list of programs. This resulted in the following six priority areas:

- Integration of Services/Data Collection System
- Early Brain Development
- Child care
- Family Support Services
- Early Intervention
- Prevention

Participants then created a list of specific activities or programs (with measurable indicators for each) that would be required to "turn the curve" on the six areas listed above. Finally, participants were asked to draft a budget for the list of programs and activities that were created under the six priority areas. Most importantly, the results of the Strategic Planning Workshop provided information regarding the relative importance and priorities of needs and services in Kern County. The concept of “turning the curve” and the information developed at the workshop became primary determinants of the form and content of this strategic plan by suggesting areas of focus for the Commission’s efforts and allocation of resources.

The first step in the planning and implementation of Proposition 10 in Kern County is completed with the adoption of this Strategic Plan. Proposition 10 and the enabling legislation require that such a strategic plan be adopted prior to any expenditure of funds for programs and services. After one or more public hearings and after approval by the Kern County Children and Families Commission, this plan will be submitted to the State Children and Families Commission.

STRATEGIC PLANNING PROCESS

Why Plan?

The term "strategic planning" refers to a coordinated and systematic process for developing a plan for the overall course and direction of the endeavor or enterprise for the purpose of optimizing future potential. The central purpose of this process is to ensure that the course and direction is well thought out, sound and appropriate and to ensure that the limited resources of

the enterprise (time and capital) are sharply focused in support of that course and direction. The process encompasses both strategy formulation and implementation.

The strategic planning process involves the following:

- Situation Assessment
  - External (i.e. clients, stakeholders, similar providers, technology, funding, economic conditions, regulations, etc.)
  - Internal (i.e. resources, existing assets, structure, capabilities, limitations, strategic competencies, etc.)
- Assumptions about unpredictable future events and developments
- Strategy formulation - sense of vision as to course and direction
- Intentions (vision and mission statements, goals, and objectives)
- Implementation Plans (action plans, budgets and schedules)
- Beyond the planning itself, there must be periodic monitoring of progress and developments as well as good implementation management.

Strategic planning begins by addressing the following three questions:

- Where are we today?
- Where are we going?
- How do we get there?

Planning achieves the following:

- Sets directions for the Commission, its staff and its supported agencies;
- Allocates resources in support of the Commission’s mission;
- Examines alternative programs and courses of action available;
- Identifies measurable indicators to gauge progress and success of our efforts for future planning.

Good planning leads to:

- Improved decision-making;
- More appropriate expenditure of funds;
- Success at attaining goals;
- Improved community support and involvement.

While there are many very real ancillary benefits, they all fall under the umbrella of the primary benefit, which is to optimize the organization's future potential through the formulation and realization of a well-thought-out, sound, and appropriate overall course and direction.

STATUTORY REQUIREMENTS

Health and Safety Code Section 130140 (1) (C)(ii) states the following:

> "The county strategic plan shall, at a minimum, include the following: a description of the goals and objectives proposed to be attained; a description of the programs, services, and projects proposed to be provided, sponsored, or facilitated; and a description of how measurable outcomes of such programs, services, and projects will be determined by the county commission using appropriate reliable indicators. No county strategic plan shall be deemed adequate or complete until and unless the plan describes how programs, services, and projects relating to early childhood development within the county will be integrated into a consumer-oriented and easily accessible system."

METHODOLOGY

Outcomes Based Accountability Framework

The outcomes- (or results-) based accountability framework developed by Mark Friedman and others is used in this strategic plan. Because it is of such importance to our efforts and because a clear understanding of the model is vital, this section is based almost entirely upon Friedman's paper "A Strategy Map for Results-Based Budgeting", and other of his work.

The concept of outcomes-based budgeting is simple and literally business-like: Start with the outcomes (results) we want for children, families, and communities and work backward to the means to achieve those outcomes. But how do we translate this simple concept into practice in the complex environment of public decision-making and budgeting?

We are now engaged in the work of identifying the outcomes that we want for children and families. In some cases, these efforts focus on matters of family and child well being; in other cases, they concentrate on a more broadly based articulation of the desired quality of life for children. But the challenge in each case is the same: to get from talking about outcomes to actually doing something about them. This plan uses outcomes-based accountability to attempt to answer this central "talk-to-action" question. If outcomes are things that matter for the long-term well being of our children, how do we connect them to the work of actually deciding on our course of action and allocation of resources?

Definitions

The following definitions provide the conceptual starting point for outcomes-based decision - making and budgeting:

Outcome (or Result): An "outcome" is a bottom-line condition of well being for children, families, or communities. Outcomes are matters of common sense, above and beyond the jargon of bureaucracy. They are about the fundamental desires of citizens and the fundamental purposes of government. The outcomes we are discussing are not "owned" by any single government agency or system. By definition, they cross over agency and program lines. Outcomes include such things as *children born healthy; children ready for school; children succeeding in school; young people avoiding trouble; stable and self-sufficient families; and safe and supportive communities*. These are outcomes that we want for our own families, children, and communities. If we define outcomes carefully, they will still be important in 10, 50, or 100 years. And because they have that kind of staying power, they are the right place to start thinking about what we want to achieve, and how we can get there from here.

Indicator: An "indicator" is a measure, for which we have data that help quantify the achievement of a desired outcome. Indicators help answer the question: "How would we recognize an outcome if we achieved it?" An outcome is not directly measurable by any single piece of data. There is no one complete measure of children succeeding in school or staying out of trouble. Examples of indicators are: *rates of full immunization for children ready to start school; reading and math achievement scores; high school graduation rates; and rates of teen pregnancy and drug use.* An essential element of this definition is that the data for an indicator are available, can be communicated and understood by the public and decision makers and is important in the strategies and/or policy making process. This is not about what we wish we knew, but about real-world information actually produced. And as our data systems get better, we can add to the list of indicators.

Performance measure: A "performance measure" is a measure of the effectiveness of agency or program service delivery. These are measures of how well public or private agencies and programs are working. Typical performance measures address matters of timeliness, cost-effectiveness, and compliance with standards, such as child abuse investigations completed within 24 hours of a report, or the cost of child support collections for each dollar collected. Such measures are absolutely essential to running programs well. But they are very different from outcomes and indicators. They have to do with our service response to social problems, not the conditions we are trying to improve. It is possible, sometimes common, for individual programs to be considered successful, even while overall conditions get worse.

The most important distinction in this set of definitions is between ends and means. Outcomes and indicators have to do with ends. Performance measures and the programs they describe have to do with means. The end we seek is not "better service" but better outcomes. The distinctions will help us describe resource allocation processes that are built on clear thinking about what we wish to achieve and the strategies we choose to get there.

Turning the Curve - Defining Success in a Complex Environment

Friedman believes that we often set ourselves up for failure in our work on family and children's well being by creating unrealistic expectations and impossible standards for success. A large part of this problem is attributable to the way in which we use data to define success or failure. The typical approach to defining success is what we call, for want of a better term, "point-to-point" improvement. If the juvenile violent crime arrest rate is now 506 per 100,000 youths, we tend to define success as reducing this rate to 450 over the next two years. This kind of definition of success is a setup. Most social conditions are more complex than this. These conditions have direction and inertia. This is reflected in a baseline, which is more often than not headed in the wrong direction. These directions can very rarely be changed quickly. Sometimes the best we can do is to slow the rate at which things get worse before we can turn the curve in the right direction. This is a more realistic way of thinking about success (and failure). Success is turning away from the curve or beating the baseline, not turning on a dime to achieve some arbitrary lower target. There are at least two kinds of baselines that should serve as reference points for our evaluation of success and failure in an outcomes framework:

Indicator baseline: The first is the baseline for each of the indicators. This baseline shows us where we have been on such measures as low-birth weight, or teen pregnancy, and where we are headed if we continue on our current course. These baselines can be used to show expected changes due to demographic or economic changes, such as the predicted increase in juvenile crime due to the coming growth in the population aged 14 to 24.

Cost of Bad Outcomes baseline: The second baseline is the companion-cost baseline. In this case the cost we need to consider is the "cost of bad outcomes." Much, if not most, government spending for children and families, other than elementary and secondary education, is spent to address bad outcomes: children born unhealthy, children not ready for school, not succeeding in school, not staying out of trouble. The costs of these bad outcomes show up in both governmental and non-governmental expenditures. It is possible to measure and track these expenditures, and to begin to frame our social and fiscal policies in terms of reducing the growth in these costs.

Each baseline, in turn, has two components: an historical component and a forecast component. Forecasting is at best an inexact science, and forecasts should reflect a reasonable range of possible future courses - high, medium, and low, or optimistic, best guess, and pessimistic. As Yogi Berra once said, "Forecasting is difficult, especially about the future."

While forecasting can be difficult and even risky, the forecast component is very important. First, it communicates a powerful message about what we can expect to happen if we stay on our current course, and it can be used to frame the fundamental question in this work about whether that expected course is an acceptable one. Second, it provides a reference against which to look at data as it all comes in and make judgments about how we are doing month-to-month, quarter-to-quarter, and year-to-year. These kinds of processes can and should be dynamic, using data to test ourselves and our strategies on a regular basis.

Two other uses are worth mentioning, although we will not discuss them much here. The cost-of-bad outcomes baseline can help set up a different way of approaching how we finance the investments necessary to turn the curve. When cost-of-bad outcomes analyses are completed, they are certain to show the high cost of bad outcomes and the relatively meager amounts embedded in the total cost now devoted to turning the curve. This picture is a first step in discussing the tangible financial benefits of an effective investment strategy to turn the cost curve, and may open the door to some non-traditional ways to finance that investment.

The second use may be controversial with the research community, but a well-established baseline is a kind of substitute for a control group in very complex environments. If we can show that our success at turning the curve(s) had some timely relationship to a set of strategies at scale (and that we were not just the beneficiaries of a fortuitous change in economic or demographic conditions), then we have credible, circumstantial evidence that these efforts are paying off. We will never be able to answer the cause-and-effect questions at the systemic level in the way we would like, but baselines, and our performance against baselines, can be a powerful, if still not fully satisfying, substitute.

Baselines are therefore an essential component of outcomes-based decision-making and budgeting**.** Without baselines, we are blinded to the reality of complex problems and complex spending patterns. We are limited by systems that inaccurately measure progress and that skew decision-making away from preventive investments. Baselines allow us to think about problems

in multi-year terms and to avoid the oversimplifications that accompany year-to-year or point-to-point comparisons.

Outcomes-based accountability uses baselines as the starting point for serious decision-making. The purpose of outcomes-based accountability can be reduced, in its simplest terms, to finding effective ways to improve our performance against the indicator and cost baselines for the most important outcomes for children, families, and communities.

STRATEGIC PLAN DEVELOPMENT AND TIMETABLE

The purpose of this section is to describe how and when this strategic plan is being developed. This is an on-going, incomplete process. This first draft was built upon the efforts of many individuals and is based upon all of the work done by Commissioners, Technical Advisory Committee members, subcommittee members and the staff of various many agencies over the last nine months or more. The Vision Statement, Mission Statement and the Guiding Principles are the foundation. Proposition 10 and the State Guidelines for the implementation of Proposition 10 are used as our model. We have also based some of our work, particularly relating to the form of the document, on the draft strategic plan published by Alameda County in November of 1999, as well as upon information we obtained from other counties engaged in the same process.

The content of the document flows directly from the work of the Commission, the Technical Advisory Committee and its three subcommittees: the Health and Wellness Subcommittee, the Child Care and Early Education Subcommittee, and the Parent Education and Support Services Subcommittee. Parents were encouraged by the individual subcommittee chairs to participate in these subcommittees and that those parents who chose to participate greatly contributed to the strategic planning process.

The goals, outcomes and strategies developed by each of the three subcommittees were compiled into three separate matrices, which were in turn summarized for ease of understanding. This information has been used to create an overarching goal/strategic result for each of the three strategic areas, health and wellness, child care, and parental education. In accordance with Friedman's outcomes-based accountability methodology, outcomes, indicators and strategies are listed for each strategic area. At this point, the voluminous work of the three subcommittees is condensed and focus is concentrated on the "turning the curve" concept. In order to do this, a small, more manageable number of outcomes and indicators are selected for each goal. The

particular outcomes and indicators selected are chosen to accurately conform to the outcomes-based accountability methodology and attempt to reflect a consensus based upon an understanding of the working groups and the results of the Strategic Planning Workshop conducted in December 1999.

The work done at the Strategic Planning Workshop was very important and useful in the strategic planning process. The results give us guidance as to the relative importance of programs, services and needs. The results also suggest priorities for resource allocation. It is important to stress that the results of the Strategic Planning Workshop will not negate or supplant the work done up to that point, but rather will help the Commission to focus more narrowly on strategies, indicators, outcomes and how to allocate the limited resources made available through the Children and Families Act in a manner most likely to improve early childhood development and "turn some curves" in Kern County.

The first draft of the Strategic Plan was provided to the Commission at its regular meeting of December 22, 1999. At that meeting the Commission determined that further work by the Technical Advisory Committee and staff was needed prior to release for public comment. As directed by the Commission, work has continued. All comments are compiled and reviewed by staff and are provided to the Commission, to the Technical Advisory Committee or to an Ad Hoc subcommittee as appropriate.

The Technical Advisory Committee reviewed the resulting working draft at their January 24, 2000, meeting and staff made necessary revisions. The first public hearing on the strategic plan was held at the Commission's regular meeting of February 2, 2000. Public testimony was received along with comments from Commissioners and TAC members. The staff revised the document as necessary for presentation to the TAC at its meeting of February 14, 2000. Further revision were made based on comments from TAC members. The Commission will consider adoption of the plan at a second public hearing to be held at the Commission's regular meeting of February 23, 2000. The adopted plan will then be forwarded to the State Commission.

IV. LOCAL COMMUNITY ASSESSMENT

COMMUNITY PROFILE

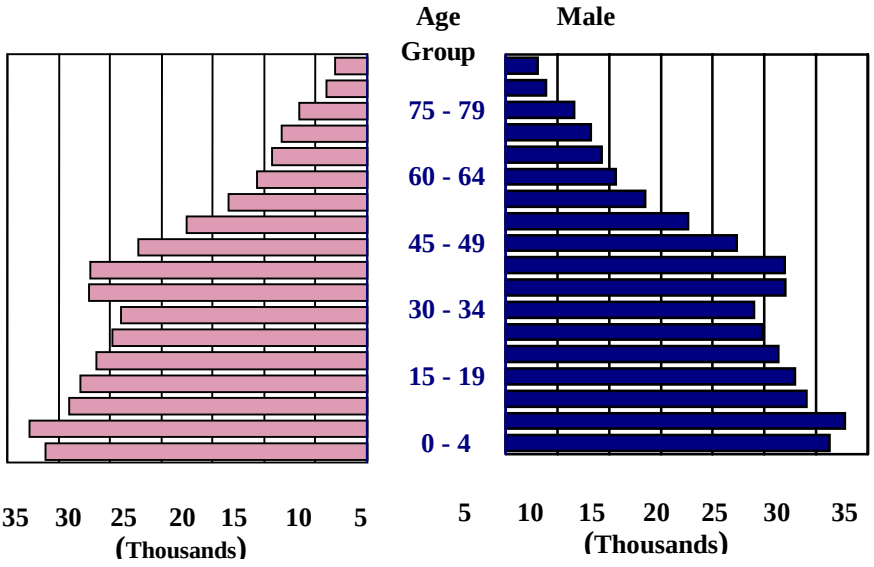
Kern is the third largest County in the State, covering approximately 8,200 square miles with a January 1998 population estimate of 639,800. The boundaries embrace urban centers, suburban cities, as well as rural and remote communities. In 1990, 83.8% of the population lived in an urban setting while 16.2% lived in rural areas. The County borders Los Angeles, Ventura, Santa Barbara, San Luis Obispo, Kings Tulare, Inyo, and San Bernardino Counties. According to the 1990 U.S. Bureau Census Data, the ethnic breakdown of the County population is as follows: (62.9%) White, (28.1%) Latino, (5.0%) African American, (1.0%) American Indian and (.2%) Other.

Table 1. California Department of Finance Population Estimates: Kern County 2,000

Age Group	Total	Caucasian	Afr. American	Latino	Other
Under 1	12,554	4,794	802	6,444	514
1	12,348	4,769	782	6,299	498
2	12,178	4,744	769	6,181	484
3	12,128	4,646	721	6,287	474
4	11,762	4,663	690	5,943	466
5	12,109	5,043	776	5,805	485
6 and above	604,293	354,415	35,738	186,754	27,386
TOTAL:	**677,372**	**383,074**	**40,274**	**22,3713**	**30,307**

Approximately eleven percent (11%) of the total population (73,079) is five years old and younger with a gender breakdown of 49% female and 51% male. Figure 1 depicts the population breakdown by age and gender.

Figure 1:
Population Age Structure
Kern County, 2000*



The challenge Kern County faces in dealing with many public health and social problems lie in the geographic makeup of the county. The large geographic area alone presents a myriad of difficulties related to transportation, access to medical services and child care and isolation of families. Resources are limited especially in some of the rural areas. Due to the cultural diversity of Kern County, language barriers are a common concern in many of the areas in attempting to provide adequate services to families. The primary languages of the county population are as follows: 75% English, 21% Spanish, and 4% other languages (in this group 25% speak Tagalog).

When comparing Kern County to the entire state of California and the U.S., it is clearly apparent that Kern has significantly higher rates of both poverty and unemployment. Recently, California State Assemblyman Dean Flores met with the County's safety net planning committee and stated that the San Joaquin Valley has been called the new Appalachia, because of the extremely low-income, high family poverty levels and high unemployment rates. He felt that this is due to the seasonal work associated with agricultural related employment. Table 2 and 3 and Figure 2 show the unemployment and poverty comparisons between Kern County, the State of California and the entire United States for the years 1996-1998 and January 1999. The data shows that Kern County has extremely high indicators for these categories. Since employment

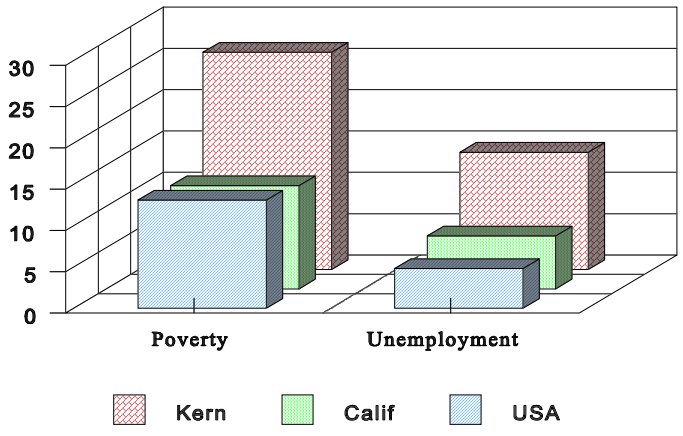
Table 2. Annual Unemployment Rates by Selected Jurisdiction, 1996- 1998, January 1999.
Source: US Bureau of Labor Statistics

Jurisdiction	1996	1997	1998	January 1999
United States	6.3%	5.9%	5.2%	5.1%
California	7.2%	5.3%	5.9%	6.4%
Kern County	15.2 %	14.0%	14.1%	14.2%

Table 3. Poverty Rates by Selected Jurisdiction, 1996 -1998, January 1999.
Source: US Bureau of Labor Statistics

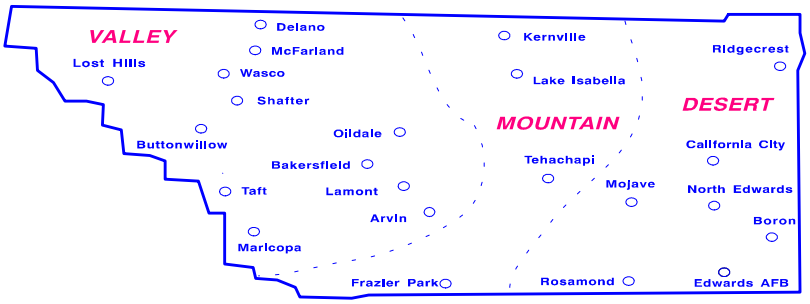
Jurisdiction	1996	1997	1998	January 1999
United States	13.7%	13.3%	13.1%	13.1%
California	16.8%	16.8%	12.5%	12.1%
Kern County	25.6%	22.4%	26.3%	24.3%

Figure 2. Percent of Poverty & Unemployment, January 1999



is usually the primary source of obtaining health care coverage, it seems that the low-income uninsured population in Kern County is going to continue to be uninsured if unemployment rates continue to be elevated. In the county's largest school district, 80% of the 14,000 children receive free and reduced lunches.

Figure 3: Map of Geographic Regions of Kern County



Three distinct geographic regions divide the county. The eastern third of the county is the Mojave Desert, the middle section straddles the Southern Sierra Nevada and Tehachapi Mountains, while the western portion of the county is the San Joaquin Valley. There are several geographic areas/ cities within each region. Each of these areas has its own unique characteristics as well as different levels of available services and resources. Transportation, access to specialized medical services and isolation are the biggest concerns in many of the outlying communities. In some of the areas, services are often obtained in adjacent Counties. Mountain barriers and the distance from Bakersfield are the most common causes of isolation and have led some of these communities to have difficulties in relating to service providers who try to deliver services but do not reside in their community. In the communities where a large proportion of the population is Hispanic, migrant farm workers, trust in public services and the public charge issue is a major barrier to accessing services.

San Joaquin Valley (western region)

Bakersfield is the county seat of Kern County and the largest populated area of the County. According to California Department of Finance Population Estimates, the city of Bakersfield had a population of about 221,700 in January 1998 (35% of the total County population.) This is an increase from the 1990 census of 174,820. According to the Kern Council of Governments, the local regional planning agency, the greater Bakersfield area has a population of 377,000. Sources of employment include farming and food processing, oil industry, and small to medium sized manufacturing businesses. There is a state university and community college located in Bakersfield.

A high level of services is available in Bakersfield and many people from outlying geographic areas must access services in the Bakersfield area. There are seven comprehensive health clinics with Comprehensive Perinatal Services Program (CPSP) and Child Health and Disability Prevention (CHDP) services. Four of the six Bakersfield Hospitals offer maternity services. Low income and Medi-Cal dental services are also available in Bakersfield. There are eighteen Women, Infants, and Children (WIC) sites. Service providers recruit and maintain bilingual staff to provide services to the growing Spanish speaking community.

Bakersfield can be divided into nine geographic areas. These areas have many common characteristics but they are also very diverse. Most individuals identify best with the small geographic area they live in and neighborhood partnerships or coalitions have been very active in seven of these areas. With the increased collaborative efforts in Bakersfield, several family service centers have been established. Multi-disciplinary teams are in place within the collaboratives to work with high-risk families.

The following table best depicts some specific characteristics of each of the Bakersfield geographic areas:

Table 4. Characteristics of the Bakersfield Geographic Areas

Target Area	% Poverty[1]	% Hispanic[1]	% Black[1]	Primary Language[1]	% Migrant[2]	% AFDC[2]	% Free/ Reduced Lunches[2]	<12th Grade Education[1*]
East	56.9%	57%	5%	42% Spanish	5%	97%	100%	55%
Central	51.4%	28%	20%	22% Spanish	2%	67%	90%	38%
Southeast	64.1%	59%	22%	47% Spanish	4%	49%	99.8%	51%
Southwest	40-84%	21%	9%	16% Spanish	3%	46%	76%	37%
Northwest	14.7%	7%	0.4%	6% Spanish	0%	4%	12.6%	16%
Northeast	22.0%	19%	2%	13% Spanish	6%	32%	69%	11%
34th St.	56.9%	17%	10%	7% Spanish	0.2%	74%	95%	39%
Oildale	40-69%	7%	0.1%	4% Spanish	0%	53%	82%	32%
Greenfield	40-63%	22%	1%	17% Spanish	--	21%	56.4%	34%

[1] Data Source: 1990 Census Tract Data * Persons 25 years and over

[2] Data Source: Selected Schools, Superintendent of Schools, 1994 -1995 School Year

Delano is the second largest city in Kern County and is located approximately 35 miles north of Bakersfield next to the Tulare County Border. The projected 1999 population is approximately 34,150 people. From 1990 census data 63% of the population is Hispanic, 20% of the population is Filipino and 2% of the population is African American. Spanish is spoken by 50% and Tagalog by 12% of the population. Many services are available locally, including two community clinics that provide CPSP and CHDP services. There is one hospital in Delano. This hospital does offer maternity services. Services are also accessed in Tulare County at a clinic located within a few miles of Delano. Medi-Cal dental services are provided. There are two WIC sites. An effective collaborative is in place with school, agency and community partners. There is also a family resource center. Sources of employment include farming and food processing, small manufacturing businesses, and a prison.

McFarland is located approximately 30 miles north of Bakersfield. The projected 1999 population is approximately 8,470 people. From 1990 census data Hispanic is the primary ethnicity with 70% of the population speaking Spanish. There is one community clinic that provides CPSP and CHDP services. Additionally, there are two WIC sites. There are an active collaborative and a family service center. This community straddles the Freeway 99, which adds additional transportation and access to services issues. Many of the residents residing on one side of the freeways have difficulties accessing services located on the other side of the freeway. Additionally, residents have difficulty accessing services in surrounding communities because of the lack of transportation between communities. Sources of employment include farming, farm products processing, and a prison.

Wasco is located approximately 30 miles northwest of Bakersfield. The projected 1998 population is approximately 20,150 people. From 1990 census data the primary ethnicity in Wasco is Hispanic (63%) and 5% are African American. Spanish is the primary language for 54% of the population. A large community clinic that provides CPSP and CHDP and dental services and WIC services are located in Wasco. A local collaborative is active. Transportation is available in town, but is not readily available for services out of town. Sources of employment are farming, farm products processing, and a prison.

Lost Hills is a small farming and oil community located approximately 50 miles northwest of Bakersfield near the border of San Luis Obispo County. The 1999 estimated population was 1,398. Hispanic is the primary ethnicity (76%), with 70% of the total population speaking only

Spanish. A small clinic is located in Lost Hills that has CPSP, CHDP, WIC services and a dental program. This area is geographically isolated from other communities. Most San Joaquin Valley towns have large migrant populations; however, it is estimated that 77% of Lost Hills' population is migrant. Transportation is a particularly difficult issue for those needing to access services outside of Lost Hills.

Shafter is located 20 miles north west of Bakersfield. Estimated population for 1999 was 11,250. Fifty-two percent of the population is Hispanic, 3% is African American. A small clinic has been recently opened in Shafter with limited services. Shafter residents also access services in Wasco. Shafter has a Healthy Start Planning Grant and a new collaborative. Primary employment is from farming and related industry. Transportation is a problem between communities.

Buttonwillow is located approximately 25 miles west of Bakersfield. The January 1999 estimated population for Buttonwillow is 1,406. According to 1990 census data 44% of the population is Hispanic, and 7% is African American. Thirty-seven percent is Spanish speaking. There is a community clinic with CPSP, CHDP, WIC and dental services. Additionally, Buttonwillow residents access services in Shafter, Taft and Bakersfield. Buttonwillow high school students attend school in Shafter. There are a Healthy Start planning grant and a collaborative. Farming and farming related businesses provide employment opportunities in Buttonwillow. Transportation between communities is not available.

Taft is located approximately 45 miles west of Bakersfield. It is close to the Santa Barbara County boarder. East from Taft is the small town of Tupman; northwest are Fellows and McKittrick. The 1999 estimated population of Taft and surrounding areas was 22,000. Census data for 1990 reports that 4% of the population of Taft is Hispanic, with 8% of the population being Spanish speaking. From observation, however, the Hispanic population of Taft is growing because of the availability of low cost housing and because of the need for farm labor to work in the fields located outside of Taft. There is one clinic with CPSP and CHDP services. There is a hospital with no maternity services. There are two WIC sites located in Taft. Services are also accessed in Bakersfield. There is a "Together We Can" collaborative developing. In past years the oil industry thrived in the Taft area. In the past ten years the oil industry has declined, but farming in the area has increased. A prison is located outside of Taft. Residents have a bus system between Taft and Bakersfield. There is a community college in Taft

Maricopa is located approximately 45 miles south west of Bakersfield. It is also located close to Taft. Services are accessed in Taft. Taft's "Together We Can" collaborative makes attempts to include Maricopa residents and service providers in the collaborative. Residents of Maricopa are predominately retired oil workers, prison employees, and farm workers. There are also persons employed on an ostrich ranch. Transportation is not available to Taft or to Bakersfield.

Lamont is located approximately 15 miles south of Bakersfield. A 1999 population estimate for Lamont was 12,691 persons. In 1990 census report 78% of the population was Hispanic with 69% of the population having Spanish as their primary language. Lamont has a large clinic that provides CPSP, CHDP, and dental services. There are two WIC sites in Lamont. Services are generally accessed locally or in Bakersfield. A strong Neighborhood Partnership has been well functioning in the community for more than four years. There is also a family service center. This area was recently awarded an Answers Benefiting Children (ABC) grant to work with high-risk families. Agriculture is the primary employment source in Lamont. A federally sponsored farm labor camp is located in the area. Transportation is available to Bakersfield.

Arvin is located 25 miles south east of Bakersfield at the base of Bear Mountain. A 1999 population estimate for Arvin was 11,250. From 1990 census data, 78% of the population was Hispanic and 60% of the population was primarily Spanish speaking. There is a small clinic located in Arvin and two WIC sites. Services are generally accessed in Lamont or Bakersfield. Also notable was that 61.4% of the population consisted of migrants. Agriculture and agriculture related businesses are about the only industry employment resource.

Mountain Area (middle region)

Frazier Park is located approximately 55 miles south of Bakersfield, close to the Los Angeles and Ventura County border. The 1998 population estimates for Frazier Park was 7,324. Some residents access services in Los Angeles. There are two clinics and two WIC sites in Frazier Park. One clinic provides CPSP and CHDP services. The other clinic is a rural health clinic. From the Mountain Communities Healthy Start needs assessment most people surveyed identified emergency medical services as an unmet need for their community. The school district recently received a Healthy Start planning grant. Frazier Park and the surrounding small communities function as bedroom communities to Los Angeles and Bakersfield.

Tehachapi is located 45 miles east of Bakersfield. The estimated 1998 population of Tehachapi is 6,575. From 1990 census data 10% of the population is Hispanic and Spanish speaking. There is one rural health clinic. There is also a hospital with no maternity services. There are also a rural health clinic and a WIC provider. Services are also accessed in Mojave, Bakersfield, and Lancaster in Los Angeles County. From the United Way needs assessment emergency medical services was identified as the number one community priority. Tehachapi recently received a Healthy Start planning grant. Major employment sources are railroad, farming, mining, a wind energy harnessing plant, military and military related services and a prison. This area also serves as a bedroom community to Bakersfield and Los Angeles County. Transportation is a barrier to accessing services.

Kern River Valley is located 55 miles northeast of Bakersfield by way of a rugged mountain road. The major cities in this area are Kernville, Lake Isabella, Bodfish, Mountain Mesa, Weldon and Onyx. Statistics gathered from 1990 census data indicate that 3% of the population is Hispanic and 2% of the population speaks only Spanish. There are two clinics in the area. One clinic provides CPSP and CHDP services. The other clinic is a rural health clinic. There is a hospital that does not offer maternity services. Additionally, there are two WIC sites in Kernville. A concern from perinatal outreach staff was that all of the service providers contacted in the area declined educational materials written in Spanish, stating that there were not serving Spanish speakers. From 1990 data, 41.9% of the population is at or below the poverty level. The area is geographically isolated, so accessing services is sometimes a challenge. They have a collaborative that is very productive, a Healthy Start planning grant and a new family service center. Major employers in this area are an electric company and in services related to recreation. A large portion of the community population is retired. Many of the homes are vacation homes.

Mojave Desert (eastern region)

Mojave is located 65 miles east of Bakersfield in the Mojave Desert. There is a rural health clinic and one WIC site located in Mojave. A collaborative exists in Mojave. Occupational opportunities are the railroad, cement producing and mining industries. Some residents are in the military or are employed by the military in Edwards. Transportation is a barrier to accessing services.

Rosamond is located 75 miles southeast of Bakersfield. The 1999 population estimate was 9,922. According to 1990 census data, the Hispanic population is 16%. However, service

providers in the area indicate that the Hispanic population is growing. Rosamond is located close to the border of Los Angeles County and serves as a bedroom community to that county. Residents employed in Rosamond work for small mining operations and in farming. Many retired persons reside in Rosamond. Residents employed outside of the Rosamond area commute to places such as the Edwards Air Force Base, Mojave and the Los Angeles County. In regard to social services, there are two *CHDP* providers and one *WIC* site in Rosamond. Rosamond recently received a Healthy Start planning grant and has a new family service center. Information gleaned from recent meetings with managed care providers suggests that Rosamond is the only Kern County community currently *carved out* of managed care.

Most medical services are accessed eleven miles away in Lancaster, which falls within the Los Angeles County. Most pregnant women choose to deliver at Antelope Valley Hospital in Lancaster while others will travel into Bakersfield or Ridgecrest to deliver. **California City** is located 75 miles east of Bakersfield. The estimated 1998 population was 8,800. There are two CHDP providers, a rural health clinic, and one WIC site. High school students attend school in Mojave. Residents work at Edwards Air Force Base and in the mining industry. Input from community sources indicates that there is high usage of met amphetamine and alcohol in the community.

Boron and North Edwards are located approximately ninety miles southeast of Bakersfield. Boron is located close to the border between Kern and San Bernardino Counties. WIC services are provided on the Air Force Base in Edwards and by way of a mobile van in Boron. Mining, a prison (located in San Bernardino County) and Edwards Air Force Base are the major employers. Many retirees who were once employed by the U.S. Borax Company reside in these areas.

Ridgecrest, located 120 miles northeast of Bakersfield, is located close to the border between Kern and Inyo Counties. The estimated population for 1998 was 28,100. From the population estimates, it appears that the population is declining. North of Ridgecrest is the China Lake Naval Weapons Center. Services are relatively plentiful in Ridgecrest. There is a public health district office located in the area; there are two clinics, one with CPSP and both with CHDP services. Additionally, there are a hospital and a WIC office. The former provides maternity services and the latter provides nutrition services; a family service center is also present. There is a community college. The following table summarizes some specific characteristics for each of the outlying areas of Kern County:

Table 5. Characteristics for each Outlying Area of Kern County

Target Area	% Poverty[1]	% Hispanic[1]	% Black[1]	Primary Language[1]	% Migrant[2]	% AFDC[2]	% Free/ Reduced Lunches[2]	<12th Grade Education[1*]
Buttonwillow	52.9%	44%	7%	37% Spanish	29.3%	24.9%	69.7%	54%
Shafter	49.3%	52%	3%	43%Spanish	36.8%	27.8%	81.1%	55%
Wasco	64%	63%	5%	54% Spanish	60.4%	23.2%	67.6%	59%
Lost Hills	73.1%	76%	--	70% Spanish	77%	9.9%	96.7%	82%
Delano	63.7%	63%	2%	50% Spanish 12% Tagalog	15.6%	22.8%	87.6%	58%
McFarland	68.7%	80%	--	70% Spanish	34.9%	17.2%	80%	67%
Arvin	68.5%	65%	--	60% Spanish	61.4%	19.1%	93.9%	69%
Lamont	69.6%	78%	--	69% Spanish	19.9%	25.8%	95%	72%
Taft	46-50%	4%	--	8% Spanish	--	31.3%	57.8%	38%
Kern River	41.9%	3%	--	2% Spanish	--	36%	58.2%	31%
Ridgecrest	50-100%	4%	2%	3% Spanish	--	12.7%	34.1%	16%
Edwards/ Boron	43-45%	9%	8%	5% Spanish	--	5.3%	32.6%	12%
Rosamond	40-49%	16%	2%	13% Spanish	0.3%	17.7%	45.9%	33%
California City	21.4%	10%	10%	6%Spanish	--	12.2%	30.5%	17%
Mojave	40-51%	21%	--	17% Spanish	--	21.7%	34.4%	29%
Tehachapi	40-56%	10%	1%	10% Spanish	--	10.6%	25.2%	18%

[1] Data Source: 1990 Census Tract Data * Persons 25 years and over

[2] Data Source: School Districts, Superintendent of Schools, 1994 -1995 School Year

COORDINATION WITH EXISTING PLANNING BODIES

Kern County has been very successful in bringing together County Departments, public and private community agencies, schools, community organizations and interested community members to help build and sustain healthy families and enrich the lives of children living in Kern County. In 1992 the County Administrative Officer brought together Department heads of the County Public Health Department, Mental Health Department, Human Services Department, Probation Department, and the County Hospital to begin to look at ways to integrate services for children, eliminate duplication and develop a seamless delivery system for children's services. Top-level management from the schools and other community organizations working with children were brought on board to collaborate with the County Departments. This led to the development of the **Network for Children** which consists of a 45-member Board of Trustees who are top level management from the County departments, schools, community agencies, private business, service clubs, local government, and religious leaders. The Network developed two priority outcomes for the community: "Kern County children will be Safe" and "Kern County children will grow in a positive learning environment." Child Deaths, school attendance, and graduation and dropout rates are being used as indicators to measure the success of achieving the two priority outcomes. This year an action plan was completed detailing activities the Network hopes to accomplish in these two areas. This organization has worked closely with the commission in assisting with development of the strategic plan.

The **Kern County Collaborative** works under the auspices of the Kern County Network for Children. This group was originally developed to offer a forum for communicating with County departments, community agencies, and the schools as they were applying for Healthy Start grants. As local neighborhoods began to develop neighborhood collaboratives or partnerships, the Kern County Collaborative became the forum for these local collaboratives to come together and share ideas. Now there are four (4) full time paid staff that support the collaborative and offer technical assistance to local neighborhood groups. There are now 21 neighborhood collaboratives that are active in neighborhoods throughout Kern County. This group has been utilized by the commission to provide input on the plan.

Some other local groups that will most likely be involved in the implementation of the plan include:

- **Healthy Mothers, Healthy Babies** which brings together representatives from County Departments, Medi-Cal Managed Care Plans, California State University, Nursing Program, Adolescent Family Life Program, and other community organizations that are interested in improving outcomes of pregnant women and their infants.
- The **Referral Assistance Network of Kern County (HelpLine)** which initially worked at creating a countywide system that could provide information on resources to individuals in need. A comprehensive computerized information and referral system was developed and one of the local nonprofit community organizations took on the responsibility for administering the system, now called HelpLine. The database now has more than 1,451 programs listed has made more than 42,000 referrals since July 1998. The Referral Assistance Network serves in an advisory capacity to HelpLine. .
- **Safety for all Kern Families Through Empowerment (S.A.F.E.) Coalition** which is a county-wide network of concerned citizens, business leaders and health and social service providers who serve children, parents, and teens to promote public safety, especially passenger and driving safety.
- **Community Action Plan and Strategy (CAPS)** which is a group consisting of representatives from Managed Care, WIC, Black Infant Coalition, Community Connection for Child Care, the Network for Children, Department of Human Services, CSV, AFLP/Cal Learn, Mercy Health Care, health care providers, UC Cooperative Extension, and University Nursing Program. This group provides community input to MCAH program activities and assists with program planning.
- **Kern County Breastfeeding Promotion Coalition** which is a group of representatives from local hospitals, WIC programs, Medi-Cal Managed Care plans, community clinics, County and nonprofit organizations, breastfeeding supply companies, childbirth educators, Certified lactation Educators, Lactation Consultants, physicians, nurses and anyone interested in promoting breastfeeding.
- **Kern County Tobacco Coalition** which brings together representatives from the Department of Public Health, medical providers (including a Pediatrician, Thoracic Surgeon, a Pharmacist), community based organizations, tobacco cessation programs, City School District, Kern County Superintendent of Schools, American Cancer Society, American Lung Association, Heart Association, an attorney and other community members interested in tobacco cessation activities.
- **Kern County Lead Poisoning Prevention Coalition** which brings together representatives from the Department of Public Health, Environmental Health, community based organizations, Community Housing Resource Board, California Water, Bakersfield Association of Realtors, and Kern County Superintendent of Schools to work on lead poisoning prevention activities.
- **Black Infant Coalition** which consists of interested community members, community based organizations, the local churches, Cal Works representatives, and the Department of Public Health and provides a forum for groups providing services to the African-American population to communicate with each other.
- **Child Care Council** which brings together representatives from various service areas and focuses on local child care issues.

COMMUNITY OUTREACH

The Commission is reaching out to the community in a number of ways and for a number of important reasons. The Commission desires to:

- Inform the public regarding the Children and Families program
- Inform the public regarding the efforts to develop a strategic plan
- Involve the community in planning and implementation efforts
- Include interested individuals and agencies in planning and implementation efforts

Community Meetings

The Commission has held, and continues to hold, regular meetings in various areas of the County. The meeting dates and places are noted elsewhere in this document. At each meeting of the Commission a time is set aside for public presentations. Also at each meeting representatives of local collaboratives have been invited to make presentations regarding their programs, activities and needs. Representatives from collaboratives in Ridgecrest, Taft, Delano, Rosamond, Frazier Park, Bakersfield, Lamont and Wasco have attended meetings and made presentations.

The Commission also conducts community meetings for the purpose of obtaining input on the strategic plan. The dates and places of meetings held are listed earlier in this document. Each of these meetings was facilitated by a Commissioner and followed a facilitator's outline designed to elicit comments about the programs and services available in the various communities in Kern County and to encourage the participants to create an ideal program for their community. Individual Commissioners and Technical Advisory Committee members also used this same facilitator's outline to conduct additional meetings in various settings and languages to probe deeper into the community**.** The information gathered at these forums is tabulated and used by staff and the Technical Advisory Committee in the formulation of the strategic plan. Please refer to Appendix A, Summary of Focus Group Meetings, for a detailed description of these meetings.

Parent Survey

The Commission developed a Parent Survey, which has been, and continues to be, administered to persons throughout the County. This survey is designed to gather information about children

and families. Like the information gathered from community meetings, the survey results have been used by staff, by the Technical Advisory Committee and its subcommittees in the formulation of the strategic plan. Please refer to Appendix B, Parent Survey, for additional information.

Strategic Planning Workshop

The Commission invited the public to attend the Strategic Planning Workshop discussed previously in this document. Although the majority of the participants in that event were Commissioners and committee members, interested citizens who attended were welcomed and encouraged to participate freely.

The success of the community outreach process has been due primarily to the collaborative work of the many formal and informal community groups in Kern County. Community coalitions in particular played an important role in getting this work done as quickly and efficiently as possible.

ASSET MAPPING

Asset-based planning begins with identifying a community's capacity, needs and assets, and typically includes the development of asset maps. Kern County community planners, service providers and policy makers have over the past several years worked diligently to develop and document information on local services for children and families.

The Technical Advisory Committee began its Strategic Planning process by forming a Needs Assessment Subcommittee, which was composed of representatives from various educational, governmental, and community agencies and organizations. This subcommittee completed an asset map for the county that describes the community's capacity, needs, and assets. This information may be found in Appendix C, Greater Bakersfield Resources and Kern County Resources.

Services for children ages pre-natal to five years old are listed according to the name of the city and the zip code. There are two spreadsheets, one for the Greater Bakersfield area and another for the areas outside of Bakersfield. Services are categorized consistent with the Proposition 10

strategy area framework. The categories include child care and early education, health and wellness, and parent education and support services. The numbers in the grid denote the number of services available in the area.

REVIEW OF EXISTING NEEDS ASSESSMENTS

Other needs assessments have been conducted throughout the community to identify programs and services required to help families with unmet needs. Information for needs assessments were collected from a variety of sources, including surveys, focus groups, and interviews with service providers, parents, high school students, and other community members.

In 1999 the United Way of Kern County identified the County's top five needs as 1) an increase in child protection services, 2) childhood immunizations, 3) youth activities to prevent delinquency, 4) emergency medical services, and 5) programs to educate teens about pregnancy. It is interesting to note that in 1997 the United Way's top five countywide needs were the same as 1998 and 1999, but in a slightly different order. A conclusion may be drawn from this information that community members are continuing to state that their top five needs are not being met.

The Maternal, Child and Adolescent Health Program of the Kern County Department of Public Health completed a Community Needs Assessment and Five Year Plan in July 1999. Areas of concern that were identified in this needs assessment included: Lack of child care, infant mortality rates, intentional injuries, low birth weight, early entry in to and continuous prenatal care, low immunization rates, adolescent pregnancy, breastfeeding, lack of parenting skills, and substance abuse.

Several Healthy Start programs conducted their own local needs assessments throughout the County. Bakersfield City School District's Safe Harbors Initiative listed the community's top five needs of 1998 as decreasing drug and alcohol abuse, dealing with family violence, getting a job or job training, obtaining legal assistance, and locating better housing. For July 1997-June 1998, the Beardsley Healthy Start needs assessment listed its top five areas of needs as physical health, mental health, basic needs, recreation, and education.

The Kern River Valley Healthy Start needs assessment listed recreation programs, employment assistance, personal safety, medical services, and transportation as its top five categories of need. The Lamont/Weedpatch Healthy Start local evaluation for July 1997-June 1998 listed its five problem areas as health and wellness, education/job skills/employment, mental and emotional health, positive youth/adult interaction, and communication/rapport between providers and families.

In 1998, the McFarland Healthy Start needs assessment listed its top service needs as health care/medical services, parent education on issues like gangs and substance abuse, English as a Second Language, transportation at night to Delano, and job readiness training. The Mountain Communities Healthy Start needs assessment stated its top five needs as emergency medical services, public safety, recreational programs, local public transportation, and medical/non-emergency care. Please refer to Appendix F, Kern County Needs Assessments, for a more detailed listing of these needs assessment sources.

V. STRATEGIES AND OUTCOMES

To accomplish the proposed goals and objectives outlined in our mission and vision statements, an outcomes-based accountability framework was employed to facilitate turning the curve on those indicators that most accurately represent the physical, emotional, and developmental needs of Kern County's children prenatal to 5 years of age and their families. This outcomes-based accountability framework serves to 1) link seemingly unrelated programmatic goals and outcomes; 2) clearly define the "ends" sought and the "means" to achieve them; 3) offer a basis for evaluating accomplishments.

This framework is outlined in Tables 1-8 which represent the results of prioritizing the work done by four subcommittees and categorizing this work into the four strategic areas identified at our Strategic Planning Workshop December 9, 1999. Theses areas are:

- *Health and Wellness*,
- *Child Care and Early Education*,
- *Parent Education and Support Services*,
- *Integration & Data Services*.

The tables list specific program strategic outcomes, goals and objectives, child and family outcomes targeted for intervention under each strategic result, strategies for achieving outcomes, and measurable child and family outcomes indicators. Input into the content of these tables was also gleaned from information gathered from community meetings, parent surveys, focus groups with consumers, and other professional discussion groups.

We expect these strategies, short-term indicators, and outcomes indicators to change after implementation has begun as increased collaboration between agencies occurs. This framework is a work-in-progress that will continue to evolve with the collaborative efforts of Kern County's service providers, parents, and the general public.

INTEGRATION OF SERVICES AND DATA SERVICES

(Service Integration)

TABLE 1: Strategic Result: Increase the number of children raised in families that are able to support their optimal development

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Expand and enhance access to integrated multi-disciplinary prevention and intervention services to serve at-risk children and families including: the homeless and other populations with *special needs*	1. Establish or strengthen *local collaborative*s in every community in Kern County, which involve schools, government agencies, non-profits, businesses, the faith community, parents, students and other community members 2. Utilize and/or develop *Family Resource Centers* in *neighborhoods* where there is a high incidence of *early risk* and/or families in crisis 3. Within communities and *neighborhood*s, develop and/or enhance integrated service teams of social workers, health workers, early childhood workers, mental health workers, job developers, Cal Works workers, and paraprofessionals that can coordinate efforts to support children (prenatal –5), parents and families, including foster children (0 to 5), and members of their foster families (e.g. provide outreach to non-English speaking families) 4. Establish and/or expand *home visitation programs* for families with children prenatal to 5, including children in out-of-home care . 5. Develop or expand multi-lingual telephone support *warmlines* to complement home visiting program. 6. Integrate *family literacy* efforts with family support programs that use a *multi-disciplinary approach* in home visits. 7. Support the use of neighborhood partnerships or other *local collaborative*s to assist in recruiting foster parents. 8. Establish or expand the personnel and communication resources of centers that link *special needs* populations with appropriate services: Perhaps by establishing mobile resource centers to link families falling beyond the community center approach (the homeless, etc.).	1. Number of communities with *local collaborative*s 2. Number of communities with *family resource centers* 3. A) Number of multi-disciplinary teams working in neighborhoods and communities. B) Number of integrated preventative service programs serving families at risk in their local *neighborhoods* and communities 4. A) Number and capacity of *home visitation programs* in each community in Kern County B) Number of families receiving home visiting services each year C) Number of child abuse and neglect cases opened on families who have received home visiting program services. D) Number of out-of-home placements for families who have received home visiting program services E) Number of reported domestic violence incidences for families who have received home visiting program services F) Number of case managed families that show progress on the *Social Condition Matrix* 5. Number of *warm lines* linked with home visiting programs 6. Number of families served by *family literacy* tutors 7. A) Number of foster parents recruited through *neighborhood* partnerships and *local collaborative*s B) Number of foster homes retained in each local community 8. Number of new methods created to link *special needs* populations with services	• By year 2005, there will be a statistically significant reduction in the number of children needing intensive multiagency services • By year 2005, there will be an increase in the number of Kern County children ready for kindergarten as measured by the **kindergarten entrance exam** (a tool will need to be created to achieve this) • By year 2005, local collaboratives and family resource centers are sustained and available to a greater number of people. • Survey results will show that at least **90%** of phone callers report being satisfied with telephone support and referral service • Children linked with a *local collaborative* and/or receiving services from an integrated service team will demonstrate improvement on baseline *developmental milestone assessment test* • By the year 2005, foster care placements will be more stable with less multiple placements.

INTEGRATION OF SERVICES AND DATA SERVICES
(Data Collection)

TABLE 2: Strategic Result: **Existing data collection systems will be integrated and universal assessment tools will be developed to better serve the needs of children 0-5 and their families.**

• **OUTCOMES**	**STRATEGIES**	**SHORT TERM INDICATORS**	**OUTCOME INDICATORS**
• Develop countywide uniform risk assessment, data collection and evaluation systems to facilitate sharing of information between service providers, parents, and the community	1. Develop a universal risk assessment tool to be utilized by preschools, child care centers, and other service providers to assess families with children ages prenatal -5 and a) identify those who may be affected by alcohol or drug use in the home; b) assess the child's cognitive, emotional, and psychological development 2. Develop a system to collect and report relevant data for the prenatal– 5 population 3. Develop an integrated service delivery data collection system where service providers will be able to access data on a client to identify other providers that are currently or have previously provided services to the client 4. Develop a "universal evaluation system" for services to children prenatal - 5 and their families. 5. Provide support to a county collaborative/network that provides technical assistance to *local collaborative*s, promotes integration of services, and develops countywide data collection and evaluation systems	1. A) Number of new assessment tools developed B)Number of existing tools that were a) identified and made available to a greater number of service providers; b) updated or improved to reflect the needs of Kern County's children C)Number of children identified to have "*special needs*" D)Number of families on a tracking System E) Develop a satisfaction survey for process review of assessment tools. 2. Number and types of methods created to facilitate collection of data for specific purposes: e.g., for "injury surveillance" 3. Number of providers able to easily access useful, well organized client data 4. Number, quality, and types of services available to children prenatal -5 as determined by the "universal evaluation system"	• Improved continuity of care: families will be appropriately referred and services given tracked • Decrease in duplication of services: i.e. child will not be repeatedly assessed with same assessment tool for different services within short periods of time. Scores will be shared between programs when authorized by parents and when deemed appropriate • Percent of families who are satisfied with services • Percent of data that has a baseline. • Percent of data that is consistently available. • The system is used by policy makers. • The data collection system is sustained, fully funded on a long term basis and it is used by Prop. 10 recipients.

HEALTH AND WELLNESS
(Prevention)

TABLE 3: Strategic Result: **Children will have good physical and oral health**

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Reduce the prevalence of obesity in children birth to 5 years • Decrease the percentage of children 1 to 5 years of age with dental caries • Reduce injuries and deaths resulting from intentional and unintentional injuries in children ages prenatal –5	1. A) Establish and expand *nutrition programs* that target parents and day care providers of preschool children B) Increase the number of schools, daycare settings and community programs that include a nutrition education component in their curriculum C) Assist families in obtaining fresh fruits and vegetables by increasing the availability of community gardens and Farmers Markets D) Use the mass media to educate parents and the community about nutrition and the importance of physical activity E) Ensure families that qualify and are in need of food stamps are getting them. 2. Establish and expand dental programs which may include: • Teaching children and families correct dental hygiene • Increasing funding for low-income children to cover all necessary dental treatment who are not insured or eligible for any other publicly funded programs • Early intervention dental health programs, which include screening, prophylaxis, sealants, and referrals • Fluoridation of the water in Kern County cities as needed • Baby Bottle Tooth Decay/Early Childhood Caries (BBTD/ECC) workshops to licensed child care providers 3. Establish and expand safety/ injury prevention programs which may include: • Providing information to health care providers, child care providers so they can educate their clients; providing early elementary, preschool and day care center safety fairs for parents and children using culturally and linguistically appropriate verbal and written information • Educating the community, parents and child care providers: the need for parental and adult supervision of children; the importance of smoke alarms; pool barriers, gun safety, bicycle helmets, vehicle restraints, etc.	1. A) Number of *nutrition programs* tailored for parents and day care providers of preschool children B) Number of schools, daycare settings and community programs including a nutritional component in their curriculum C) Number of community gardens and Farmer's Markets that are available D) Number of parent sessions offered through mass media E) Hire percent of families using food stamps. 2. A) Number of low-income children receiving appropriate dental services B)Number of workshops on BBTD/EDCC to licensed child daycare providers C) Number of medical and dental care providers educated about the importance and proper protocol for working with the oral health of children 0-5. 3. A) Number of intentional and unintentional injuries to children 0-5 B) Number of intentional and unintentional child injuries resulting in child deaths C) Number of programs to educate parents and caregivers.	• Survey shows a decrease in obesity problems for children: a) Enrolled in day care centers featuring a nutrition education component in their curriculum, and: b) Whose parents participate or haveparticipated in a nutrition education class • Follow-up of dental screenings show fewer caries • There is an increase in the number of treatment referrals that are successful and completed • Emergency and urgent dental care visits to local ER and medical clinics are decreasing • Absences from school for dental health problems and emergencies have decreased • Decrease in number of children visiting the ER because of unintentional or intentional injuries • CPS data shows a decrease in the number of substantiated child abuse reports • Vital Statistics show a decrease in the rate of child deaths due to use of firearms, drowning, poison, fires, bicycle accidents, and car accidents where no child seat or vehicle restraints were used, etc

HEALTH AND WELLLNESS
(Early Identification, Referral, & Intervention)

TABLE 4: Strategic Result: **Children will be safer, healthier, and ready to learn**

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Increase and improve early identification of special conditions, child abuse, etc. • Increase early interventions: i.e., quickly form and deploy multi-disciplinary teams to work with children with high risk and/or behavior issues • Expand existing community resources that will identify and provide services for all children with early emotional, behavioral and learning challenges • Provide training for professionals in early identification of conditions, appropriate referrals, and providing early intervention	1. Provide education to health care providers and other professionals to increase knowledge on methods of early identification, appropriate referrals, and effective interventions. Topics to include: identifying at-risk mothers (underweight, overweight, and substance abuse); early detection of special conditions before 5 years of age and make appropriate referrals; identify, support and educate women of childbearing age on the effects of alcohol, tobacco, and drug abuse and make appropriate referrals; the importance of proper oral health habits, including discontinuing bottle use after 12 months of age; available resources including the availability of support groups and services for parents and children with special needs 2. Establish and enhance *home visitation program*s to provide case management services to women and children during the prenatal period, postpartum period, the infant's first two years of life, and children through 5 years of age who have special conditions 3. Increase the level of early intervention services, such as speech and language development, provided in outpatient settings; preschool settings and child care settings, by specialists and trained child care providers 4. Develop a system for early identification and intervention utilizing a *multidisciplinary approach* to address behavioral and learning challenges 5. Enhance and increase training to professionals on special conditions, early detections of learning disabilities, attachment/bonding, and referral resources 6. Establish an early identification multidisciplinary team to deal with children with behavioral an early mental health issues	1. Number of professionals receiving education in early identification of special conditions, appropriate referrals, and providing early intervention 2. Number of at- risk families participating in *home visitation program*s 3. Percent increase in number of children receiving services	• Decrease in the rate of childhood illnesses, behavioral problems, and incidence of childabuse and neglect for families participating in home visitation programs when compared to a general population • Conditions such as hearing, vision, and dental problems will have been identified prior to child starting Kindergarten as reflected by the decrease in number of first-time referrals made by schools to health specialists • Decrease in tobacco and alcohol use in families with children 0 to 5.

CHILDCARE AND EARLY CHILDHOOD EDUCATION
(Quality Child Care)

TABLE 5

Strategic Result: Children will be cared for in an environment that supports their optimal development.

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Increase the proportion of childcare providers accessing available educational and support services • Increase the proportion of children who are cared for in a culturally appropriate, safe, stable, healthy, and nurturing environment	1. Recruit culturally diverse applicants for early childhood training 2. Establish and provide scholarships to child care providers to progress in the *Child Development Permit Matrix* 3. Establish comprehensive, coordinated professional development and distance learning programs for childcare providers 4. Establish and provide tiered reimbursements based on training completed in early childhood education 5. Establish and provide a "benefit package" to child care providers that includes insurance and a substitute pool 6. Offer business trainings (eg. Record keeping, management, accounting, personnel issues), technical assistance, and management consultation to child care providers. 7. Offer grants and micro-enterprise loans for start-up, renovation and repair 8. Provide funding for additional business facilitator positions to serve all of Kern County 9. Expand nutrition programs in child care settings by offering trainings and incentives 10. Expand the Exempt Provider Training and Support Services Program by offering trainings and incentives throughout the County	1. A) Number and percent of child care providers representing Kern County's various ethnic and cultural populations B) Percent increase in culturally diverse personnel entering the field 2. Number and percent of child care Providers (those receiving scholarships) who have progressed in the Child Development Permit Matrix 3. Number of child care providers participating in distance learning 4. Number of child care providers receiving tiered reimbursements 5. Percent increase in child care providers staying in the field per year .6. Number of child care businesses sustained and expanding to serve more children 7. Number of exempt providers attending training and receiving incentives 8. Number and percent of child care providers meeting safety/quality standards as measured in the "Desired Results Developmental Profile" assessment tool 9. Maintain a low number of substantiated complaints against childcare providers.	• Survey of families with young children shows: a) percent that are satisfied with their child care provider b) percent of families that continue with current provider over a certain time span- demonstrating continuity for child care • A universal assessment tool (needs to be developed) shows that children who remain in the same childcare setting for a period of two years or more will receive an average or better score at K entry • Percent increase in the number of childcare providers meeting safety/quality standards as measured in the "Desired Results Developmental Profile" assessment tool • Percent decrease in annual turnover rate of childcare providers in Kern County as a result of these strategies • Percent decrease in the number of injury incidence at child care settings.

CHILD CARE AND EARLY CHILDHOOD EDUCATION
(Improved Data Systems)

TABLE 6: Strategic Result: Child care professionals, policy makers, parents, and others will be able to make informed decisions regarding child care

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Increase the quality and quantity of child care data • Increase the number of child care professionals, parents and others with the ability to access and obtain timely child care data in one central location	1. Fund the existing *Centralized Child Care Information Service* so that subsidized agencies can participate and hire additional staff to help maintain and maximize the system c) Establish a "one-stop" Data Clearinghouse to create and update on a continuous basis child care data including *GIS mapping services*	1. Number of child care homes and centers established in areas of greatest need as a result of new child care data gathered 2. Number of child care professionals, parents and others able to access child care information from the "one-stop" Data Clearinghouse	• Percent increase in childcare homes established in areas of greatest need • Percent increase in "childcare language" included in long term *economic development plans* (Kern County and its incorporated cities)

CHILD CARE AND EARLY CHILDHOOD EDUCATION
(Health Consultancy)

TABLE 7:Strategic Result: An increase in integrated services and linkages between childcare, health care, dental, mental health, parent education, family supportive services and the provisions of early developmental assessments, by utilizing the services of health care consultants, family service providers and programs like Search & Serve.

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Increase access to integrated services for families and children prenatal-5 through family child care homes and centers	1. Expand Family Service Providers' services through *neighborhood* collaboratives to conduct home visits to child care providers to identify and link the children in their care to needed services by hiring additional Family Service Providers 2. Hire *health care consultants* to provide preventative services (i.e., screening, referrals, follow-up for child health needs) and indirect services (consultation *to family service providers* and child care providers) and enrollment of children in Healthy Families, Medi-Cal for Children, etc. 4. Improve awareness and increase the number of appropriate referrals made for children with *special needs* through *Search And Serve*	For children linked to family service providers and health consultants: 1. Number of children with up to date physicals, dental care, and immunizations 2. Number of healthcare services accessed by children and families 3. Number of "children with *special needs*" linked to a health care consultant and receiving early intervention	For children linked to family service providers and health consultants: • By the year 2002, 75% of these children will be receiving comprehensive physicals, including vision and hearing exams • By the year 2002, there will be a 10% increase in the number of children receiving yearly dental exams • By the year 2002, 90% of children 0-5 years of age will have received all of their immunizations

PARENT EDUCATION AND SUPPORT SERVICES

(Healthy Early Brain Development)

TABLE 8: Strategic Result: **Children reaching developmental milestones: excelling academically, socially, physically, and emotionally**

OBJECTIVES	STRATEGIES	SHORT TERM INDICATORS	OUTCOMES INDICATORS
• Increase awareness and education to parents, caregivers, and the community about health, mental health, quality childcare, parenting skills, and available community resources • Increase the percentage of women who choose to breastfeed • Increase the number of children and parents of young children who have access to mental health services. • Increase appropriate referrals for mental health and early childhood parenting issues.	1. Develop creative and innovative methods to distribute information to educate parents, caregivers and the community which include: • Providing information outreach to parents, including the use of Community Health Outreach Workers/Family Advocates; linking parents and children with community services, mentor programs, peer self help groups; teaching parents about baby schools/play with your child, parent/child programs • Educating pregnant women on topics such as the importance of continuous prenatal care, the signs and symptoms of premature labor, prevention of infections, the importance of adequate nutrition, prenatal vitamins, folic acid, breastfeeding, the effects of alcohol tobacco and drug use, the importance of preventive and acute medical care for their children • Establishing parent education programs that will include information on preconceptional health, developmental milestones, positive parenting, conflict resolution, anger management, coping mechanisms, positive family and community living, and changing skills and attitudes of future parents • Promoting public awareness campaigns on topics such as prematurity prevention, low birth weight, infant mortality, hypertension prevention, diabetes management, and effect of alcohol, tobacco and drug use before pregnancy; immunizations and early preventive child health care, nutrition and physical activity, oral health education, and available resources in the community. Awareness campaigns could involve groups such as employers, the faith community, civic leaders • Breastfeeding and how to support breastfeeding mothers • Educating physicians and nurses on the latest in breastfeeding management and the importance of encouraging mothers to breastfeed immediately after birth. 1. Increase the availability of mental health programs that specialize in early childhood diagnosis and treatment 2. Provide home-based mental health services for children 0-5 and families expanding in-patient and out patient treatment programs that are tailored to pregnant women and women with small children	3. A) Number of parents enrolled in parent education programs B) Number of families assigned a "Family Advocate" C) Number of pregnant women enrolled in prenatal care, breast-feeding, and nutrition classes 2. A) Number of women who breast- feed their infants during the first six weeks, until 6 months, and until 1 year B) Number of women using lactation consultants C) Number of women receiving breastfeeding information from nurses and doctors 3. Number of mental health programs specializing in early childhood diagnosis 4. Number of children receiving home-based mental health services 5. Number of in-patient and out-patient programs tailored to pregnant women and women with small children	• Survey results of women who choose to breastfeed will show that their children: a) have fewer incidences of ear infections, colic, and other common childhood illnesses b) score well in developmental *milestone assessment tests* • Day care centers and schools will report that they have fewer children with behavioral problems • Day care center and school professionals will be able to provide referrals to a wide selection of appropriate pediatric mental health providers • Children and families will have access to and utilize mental health services

Definitions for Tables 1-8

**Please note that except for* "Short Term Indicators" *and* "Indicator Outcomes"*, terms defined here will appear in italics throughout tables 1-8.*

Baby Bottle Tooth Decay/Early Childhood Caries (BBTD/ECC)- *BBTD and ECC* are synonymous terms for caries, usually upper front teeth of very young children, caused by over exposure to sweet liquids.

CalWORKs (California Work Opportunity and Responsibility to Kids Program) - In 1997, the California legislature passed, and the Governor signed, legislation creating the CalWORKs program to replace AFDC and GAIN. CalWORKs legislation implements the federal welfare reform requirements and legislates many of the state options allowed by federal law. It now falls to counties to operationalize and implement new programs and services to serve low-income families. These new programs and services are focused on employment as the primary service to most families. Each county is required to design, within state and federal parameters, programs and services to assist low-income job-seekers to become, and stay, employed.

Child Development Permit Matrix: This matrix outlines the qualifications, requirements, and authority levels associated with specific job titles for child care workers. Please refer to Appendix F for a full description of the matrix.

Desired Results Developmental Profile Assessment Tool: the Desired Results system involves observation of children using an instrument called the Desired Results Development Profile. Developmental assessment is a process designed to deepen understanding of a child's strengths and to identify areas where a child may need additional support.

Developmental Milestone Assessment Test- These types of tests are designed to be used with apparently well children between birth and six years of age and is administered by assessing a child's performance on various age-appropriate tasks. It is not an IQ test, nor is it a definitive predictor of future adaptive or intellectual ability. The test consists of 125 tasks, or items which are arranged on the test form in four sectors to screen the following areas of function: Personal-Social; Fine-motor-adaptive (eye-hand coordination); Language; Gross Motor (sitting)

Early Risk- involves multiple factors in home and neighborhood environments that are likely to have a negative impact on the healthy development of infants and young children and include some of the following conditions: Poverty/high rate of unemployment, Low literacy/low History of substance abuse, educational levels, history of mental illness, history of family violence, social isolation, early and multiple adolescent pregnancies, and one parent families.

Economic Development Plans- Economic development plans serve as the constitution for future community development. Reasons to include child care language include 1) creates legal commitment to child care; 2) leads to positive economic impact; and 3) leads to positive societal impacts.

Family Literacy- is a comprehensive model involving both parents and children that includes the following four components: adult education basic skills, including life skills instruction, early childhood education, parent groups for education and support, parent and Child Together Time

Definitions for Tables 1-8:

Family Resource Center-A service advocate system utilized to give families a centralized location to start when they may nor know or be able to take a first step in getting the help they need to provide family friendly services. Integration with school-based. A facility located within a specific community that houses a variety of services. An easily accessible site, which acts as a central point of referral and services.

***Geographic Information System (aka GIS mapping)*:** this system is a computer-based tool for mapping and analyzing geographic data. Professionals in every field are becoming increasingly aware of the advantages of thinking and working geographically. GIS is used to create maps, integrate information, visualize scenarios, solve complicated problems, present powerful ideas, and develop effective solutions.

Health Consultant- A currently licensed health professional with public health, pediatric or child care experience and normative child development and behavior knowledge that works specifically and directly with child care providers and the children in their care in their homes and centers. Using a working knowledge of Child Care Licensing regulations, services include technical assistance, health screenings, onsite exams, consultation and referrals to resources as needed. The consultant works hand-in-hand with the Family Service Provider and local collaboratives.

Home Visitation Programs- involve well trained and caring professionals and/or paraprofessions who work with families in the home environment "… to assist parents in managing the multiple tasks of parenthood and provide structure, empowerment, assistance with problem solving, coping, and resource utilization." [from *California Safe and Health Families Program/Family Support Home Visiting Model Executive Summary, p 8. (Revised April 1999)*] Comprehensive programs address all relevant issues including basic needs, health, mental health, education, and literacy, parenting, and child development. Home visiting programs are linked to community resources and may involve either intensive, short-term services and/or long-term maintenance services.

Local Collaborative and Neighborhood Partnership- The bringing together of key representatives of the community who meet regularly to determine community needs, set priorities, make decisions, share governance and provide leadership in an effort to make the community a healthy and safe places for families.

Multi-Disciplinary Approach- A multi-disciplinary approach involves both the home visitor and the collective team of specialists who address the holistic needs of families and their children. Home visitors are cross-trained to observe and assist with the many aspects of family wellness including health, mental health, education, parenting, and child development. The specialists work collaboratively to share training, knowledge, and expertise with the home visitors and provide direct intervention when appropriate. Specialist may include public health nurses, nutritionists, social workers, mental health counselors, child development specialists, teachers, and vocational/job developers.

Definitions for Tables 1-8:

Neighborhood- is a "defined geographical area", based on population groupings. It is synonymous with the term "communities".

Neighborhood Partnership (NPs)- A neighborhood partnership is a community-driven action plan for resolving local problems within a framework of shared governance, which relies upon the reallocation, realignment and/or redirection of existing funds. NPs are creative; marshaling resources at each service site to provide training., support, and services to paraprofessionals, staff, and parent; and taking the opportunity to collaboratively find a better way to meet the needs of children and families.

Nutrition Program- *(From* Table 3, under Short Term Indicators 1A): Nutrition programs can include nutrition education, cash reimbursements for meals served to children in licensed family day care homes, or a combination of the two. For cash reimbursements, food must meet USDA guidelines.

Outcomes Indicators are data that demonstrate the effectiveness of our objectives and strategies at "turning the curve" on children's health, education, and general well being.

Search And Serve is an on-going, cooperative effort that involves state and local agencies of the Departments of Mental Health, Rehabilitation, Health, and Human Services; the County Superintendent of schools, Kern Regional Center, and community agencies that provide services to children. A vital part of the Search And Serve effort is the assistance from community members, business firms, social and civic groups, parents, and students themselves.

Short Term Indicators are milestones toward long term outcomes. They tell us whether or not the objective activity (strategy) is producing any results. Although these indicators are important, they do not tell us how successful the strategy is at "turning the curve".

Special Needs- such as but not limited to: infants considered at risk for delays, visual impairments, hearing loss, learning disabilities, communication problems, physical challenges, developmental delays, medically fragile conditions, autism, cerebral palsy, spina bifida, epilepsy, syndromes, emotional diagnoses, ADD and ADHD.

***Warmlines*:** A warmline is an organization of trained parent volunteers, serving as a telephone outreach to parents in Kern County. The volunteers offer a confidential listening ear, helping parents deal effectively with the often difficult and crucial issues that arise in child rearing. The warmline's volunteer's Listening techniques allow the callers to sort out their feelings, gain perspective on their concerns, and choose from alternative solutions that fit into their family framework. Calls of a more serious nature are referred to professional counselors

VI. FUNDING ALLOCATION

PURPOSE

The purpose of the funding allocation plan and process is to set the parameters and priorities for strategic plan funding and overall implementation. It will also identify resource allocation guidelines that adequately predict the costs of fully funding the program components in the Strategic Plan. This allocation plan will serve as a blueprint to help provide, on a community by community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services.

Definitions

The **Funding Allocation Plan** defines the process and relative priorities in the allocation of the Commission's resources. The Funding Allocation Plan provides overall guidance to the Commission and the community regarding specific categories and priorities. The Funding Allocation Plan tells us which outcomes matter most for the long-term well being of our children and how we connect them to the work of actually deciding on our course of action and allocation of resources. The Funding Allocation Plan will help us answer the "talk-to-action" question and shows us which curves we wish to turn.

The Funding Allocation Plan is separate from the **Fiscal Plan and Budget**, which deal with specific revenue and expenditure amounts within a set period of time. The Fiscal Plan and Budget implement the funding allocation plan from year to year. The Fiscal Plan and Budget are prepared using actual revenue and expenditure estimates and may make projections for multi-year periods. The Fiscal Plan will also deal with the question of maximizing the revenues available to funds our programs and the important task of investing idle funds will be addressed here.

The term **geographic equity** is used in this plan to refer to the concept that resources could or should be somehow distributed evenly among all communities. This implies that there exists some "fair share" of resources for each community based upon a commonly accepted measure such as population, or in our case, perhaps the number of children from age 0 to 5. Taken to its logical conclusion, **geographic equity** would be a matter of dividing the available funds by the number of children from age 0 to 5, and multiplying that number by the number of such children in any given community. **Geographic equity** per se is not a consideration in this funding allocation plan. This funding allocation plan does not recommend allocations based upon geography. The more important consideration is stated as one of our First Principles: *We will support programs and services for all children prenatal to 5 years of age and for their families.* This funding allocation plan offers a framework to support programs and services for all children prenatal to 5 years of age, regardless of where they or their families may live.

The funding allocation plan is based on the understanding that it will take a significant period of time, perhaps several years, to get up to full scale operation. The limitations of existing infrastructure, the size of the task ahead and the need for careful, thoughtful implementation of this unique new program require a careful plan.

As information becomes available, the funding allocation plan will also project figures for funds that can be leveraged from other sources to augment the available Proposition 10 funds. Those sources may include other county, state, and federal governmental revenue as well as private foundation, corporate, and community funding.

Proposals for multi-year programs and services will be considered and applicants may apply for funding for a period of up to three years. Funding for approved multi-year programs and services will be subject to the annual budget process and to a more frequent review and evaluation process to determine if anticipated outcomes are being achieved. Continued funding will depend upon success.

PRIORITIES

The funding allocation plan reflects a desire to balance funding in the three strategy areas of child care, health and wellness, and parental education. In addition, funds should be allocated in a way that demonstrates our commitment towards service integration and a seamless service delivery system across various health and social services agencies.

The funding allocation plan reflects our commitment to "turning the curve." We recognize that the needs of children and families in our community far outweigh the resources available through Proposition 10. We will allocate funds in a manner that will yield fewer, but more significant outcomes, rather than producing more, but less significant outcomes.

The funding allocation plan reflects our commitment to ensuring that these funds will help build capacity and infuse investments in community programs. The plan also reflects the desire to encourage creativity by making funds available for projects that further the goals and outcomes of this strategic plan. Strict adherence to accountability, performance standards, participation in

cross-disciplinary training and service integration will be required as appropriate of all funded programs.

Proposals that are comprehensive in providing their services or programs (i.e., more than one of the funding categories is included) are preferred. However, single purpose proposals will not be discouraged. Applicants should commit to serving all of the County or commit to working with existing organizations or agencies to provide the proposed program or service in a specific geographic area. Proposals for countywide programs or services must address how the program or service is to be coordinated and integrated with existing providers. Proposals that contemplate the use of funds from other sources, including matching funds, are encouraged.

The Commission prefers that programs and services be provided by local Kern County providers, based upon 1) the assumption that local providers better understand local needs and 2) a desire to keep Proposition 10 funds in the community. However, the Commission also recognizes that providers outside of Kern County may more effectively or more efficiently provide some services and programs. As a general rule, preference will be given to Kern County providers in cases where proposals are equal in all other regards.

Funding for administration will be kept at a minimum. This plan recognizes that some funds must be spent on an administrative infrastructure, for planning and to monitor program implementation. However, we are committed to utilizing every dollar possible for direct services to children and families. This implies a preference for utilizing existing resources and support from other agencies where possible as part of our own infrastructure system.

INTEGRATION OF SERVICES

The California Children and Families Commission's **Guidelines: A Resource for Developing Prop. 10 Strategic Plans** clearly explains that "The California Children and Families Act of 1998 is designed to provide, on a community-by-community basis, all children prenatal to five years of age with a ***comprehensive, integrated system*** of early childhood development services. The Act encourages the development of comprehensive strategic plans that promote integration, linkage and coordination among programs, service providers, revenue resources, professionals,

community organizations and residents in an overall effort to strengthen communities and support collaboration." In implementing Proposition 10, Kern County will build on existing collaborative efforts that have successfully integrated services on many levels.

Collaboration has become a key ingredient in improving the lives of children and families in Kern County, and many community organizations now recognize collaboration and integrated services as essential to the success of any program. Very simply put, a huge part of the success of Kern County's Prop. 10 efforts will be determined based on our ability to integrate services on a local, community-by-community basis. This section of Kern County's strategic plan is designed to provide the Kern Children and Families Commission's expectations regarding integrated services and a comprehensive service-delivery system.

The Kern County Children and Families Commission will seek to fund projects that demonstrate effective collaboration and integration of services, especially those that build on existing partnerships and networks throughout Kern County. Where such collaborative efforts or networks do not exist, agencies will be encouraged to come together to share resources, avoid duplication of services and maximize funding by working together to address the needs of children and families.

FUNDING ALLOCATION PROCESS

Submission of Proposals

Agencies or individuals wishing to be granted or loaned funds from the Children and Families Trust Fund will be required to submit an application for such funds through a competitive Request For Proposal (RFP) process. Requests For Proposals along with the necessary forms and instructions will be widely distributed to community-based organizations, cities, school districts, and other potential service delivery entities at the appropriate time. Announcement of the RFP process will be widely publicized. The schedule for acceptance, review, evaluation and consideration by the Commission is detailed below. There is no limitation on the number of applications that any particular agency or individual may file; however, applicants are encouraged to be comprehensive in their approach. Individual proposals should seek funds under only one strategy area.

Review by Staff

Applicants will be expected to submit all required information by the established deadline. Commission staff will review the proposals to ascertain their completeness. Incomplete proposals will be returned to the applicant. Complete proposals will be accepted and will be assigned to one of the four Independent Evaluation Committees for review and evaluation.

Evaluation of Proposals

Independent Evaluation Committees will be established by the Commission in each of the four strategy areas, Child Care and Early Intervention, Health and Wellness, Parental Education and Family Support Services, and Integration of Services. Each Independent Evaluation Committee will be responsible for evaluating proposals and making funding recommendations in its assigned strategy area. Independent Evaluation Committees may make site visits on a case-by-case basis to assist in making judgments about proposals.

Proposals must meet State requirements as defined in the Act and in the State implementing legislation and guidelines. Funds may only be appropriated for the purposes stated in the Act. Funds may only be used to supplement existing levels of service and not to fund existing levels of service. Funds may not be used to supplant state or local General Fund money for any purpose. Proposals must be consistent with and advance the goals, objectives, strategies and outcomes defined in the Strategic Plan.

Independent Evaluation Committees will make recommendations to the Commission regarding the approval of proposals and the amount and the duration of the funding. Independent Evaluation Committees will be responsible for making judgments among competing interests about the probable success of proposals in producing or influencing the desired outcomes stated in the Strategic Plan.

Report to the Commission

Each Independent Evaluation Committee will complete its evaluation of all of its assigned proposals and will provide its recommendations to the Commission’s staff. The staff will prepare a report summarizing the recommendations of the four Independent Evaluation Committees. This report will present the Independent Evaluation Committee recommendations, along with a discussion of the funding allocations and schedules necessary to implement these

recommendations. This report will also provide recommendations for Commission action on any or all of the proposals recommended for funding by the Independent Evaluation Committees. This report will be provided to the Commission in accordance with the established timetable. This report will also be made available to each individual or agency submitting a proposal and to the public at the same time that it is provided to the Commission.

Commission Action

At its next meeting following completion of the work of the Independent Evaluation Committees, or at any other time determined by the Commission, the Commission will consider the Committees' recommendations, along with the Commission staff report, and will take action to approve or disapprove each proposal. The Commission may also take any other action it considers necessary to implement the proposals. Simply stated, a successful proposal will have presented a convincing argument regarding which curve(s) it proposes to turn, how that turning of the curve will be accomplished and how success, or the lack thereof, will be measured using the outcomes-based accountability framework.

Contracts

Following approval by the Commission of any proposals, Commission staff will meet with each successful applicant to negotiate and execute an implementing contract. It is recognized that it may benefit both the Commission and the applicant to make changes in proposals prior to their final implementation and the Commission reserves the right to negotiate the scope of work and payment terms prior to the execution of any agreement.

Appeals

The Commission is the sole and final authority regarding the approval or disapproval of proposals and the conditions under which they are funded. At its sole discretion the Commission may consider an appeal of any decision of the Commission, including a decision to not approve all or a portion of any proposal. The Commission will establish an appeals process to hear such appeals. The appeals process will commence after the annual funding allocation cycle has been completed and after all contracts approved by the Commission have been executed. The appeals process will provide for all projects approved by the Commission to move forward according to the implementation schedule and will provide assurance that funding for projects approved by the Commission will not be at risk as a result of any appeal.

INDEPENDENT EVALUATION COMMITTEES

Independent Evaluation Committees will provide advice to the Commission regarding the programs and services sponsored by the Commission. Each Independent Evaluation Committee will be composed of five evaluators selected from the community at large. Evaluators will be persons who are interested in assisting the Commission in its work. Evaluators will be volunteers who will serve without compensation, except for reimbursement of reasonable expenses. The distinguishing characteristics of evaluators will include the desire to perform this task as a public service; the ability to understand the Commission's goals, objectives and methodology; the ability to reason and make excellent decisions in a group setting; and the time and energy necessary to devote to the task. Independent Evaluation Committees will be largely composed of persons with expertise or experience in early childhood development or a related field, although each individual evaluator may not necessarily possess such expertise or experience.

Training will be provided to evaluators to ensure a complete understanding of the requirements of Proposition 10, of our strategic plan and its vision for children prenatal to 5, of outcomes based accountability methodology, and of the role of collaboration in the delivery of programs and services in Kern County. To the extent possible, the identities of the evaluators will remain confidential and will neither be made public nor be revealed to applicants. Persons with any real or potential conflict of interest may not serve as evaluators.

Applications for the position of evaluator will be received and screened by staff. The Commission's Personnel Committee will review the list of persons best qualified and will select five persons to serve on each Independent Evaluation Committee. Independent Evaluation Committees will meet for training sessions and for evaluation of proposals in accordance with the procedures and schedule established by the Commission.

SCHEDULE

The Request For Proposals and funding cycle will be conducted on an annual basis. The schedule for the first funding cycle is as follows:

Adoption of Strategic Plan	February 23, 2000
Transmittal to the State Commission	February 25, 2000
Publish RFP	March 10, 2000 *(or earlier)*
Pre-proposal conference	March 14, 2000
Closing date for receipt of proposals	April 7, 2000
Evaluation by staff as to completeness	April 12, 2000 *(or earlier)*
Distribution to IEC's	April 12, 2000 *(or earlier)*
Evaluation by IEC's	April 28, 2000
Summary report on recommendations	May 12, 2000
Distribution of summary report	May 26, 2000 *(or earlier)*
Commission approves proposals	June 7, 2000
Negotiation and execution of contracts	June 21, 2000
Initial distribution of funds	July 1, 2000

This schedule will allow for the orderly adoption of the Strategic Plan and allocation of funds received during fiscal year 1999-2000, ending June 30, 2000. The Request For Proposals and funding cycle for fiscal year 2000-2001 will be established to allow for coordination with the preparation and adoption of the Commission's annual budget.

FUNDING ALLOCATION PLAN

This Funding Allocation Plan is based upon a projected funding availability of $15,000,000. This is a conservative estimate of the amount of money that will be available in the Children and Families Trust Fund on June 30, 2000. This Plan allows for the expenditure of funds accumulated from program conception to the end of fiscal year 1999-2000. Any excess amount will be carried over into fiscal year 2000-2001.

	First Year Allocation	
STRATEGY AREA (Turning the Curve Areas)	**Percentage**	**Amount**
INTEGRATION OF SERVICES AND DATA SERVICES Countywide data collection County collaborative network Local collaboratives, multi-disciplinary case management Family resource centers and in-home services	24.0%	$3,600,000
HEALTH AND WELLNESS Prevention of: childhood obesity childhood caries intentional and unintentional injuries child abuse Early identification, referral and intervention: training and technical assistance for professionals child care consultants integrated team for follow-up & intervention dental screening and treatment	18.0%	$2,700,000
CHILD CARE AND EARLY CHILDHOOD EDUCATION Quality child care: training for bilingual and bicultural child care providers child care matrix scholarships training and professional development benefits and financial incentives business training, technical assistance, management consultation grants and loans for start-up, renovation and repair expansion of EPTSSP and child care food programs Improved data systems: centralized child care information service data clearinghouse for child care data and GIS mapping Health consultancy health care consultants family service advocates	18.0%	$2,700,000
PARENT EDUCATION AND SUPPORT SERVICES Healthy early brain development: awareness and education for parents, caregivers and community breast feeding counseling for prenatal and parents of infants baby schools, play with your child, and similar programs geographical language barriers family services and support (family resource centers)	18.0%	$2,700,000
ADMINISTRATION	8.0%	$1,200,000
RESERVES	14.0%	$2,100,000
TOTALS	100.0%	$15,000,000

Strategies or activities listed under each strategy area illustrate the types of activities intended to be funded in each of these areas. It does not necessarily mean that every activity listed will be funded.

After the experience of the first year funding cycle, adjustments may be made in the percentage allocated to each strategy area. It may be, for example, that infrastructure needs in the Integration of Services strategy area may not be as significant in the years following startup. The Technical Advisory Committee will be expected to periodically review needs and service requirements and make recommendations for change as necessary.

The allocation for Administration is set in accordance with the enabling legislation (Kern County Ordinance Code, Section 2.100.100). As a practical matter, unspent administrative funds will automatically be part of the reserves and will be available for program expenditures in subsequent funding cycles.

VII. EVALUATION

PURPOSE

Evaluation is an important component of the strategic plan and of the Proposition 10 implementation process in Kern County. Carefully identified and collected information on program implementation and program impact will allow service providers to demonstrate the effectiveness and efficiency of their programs to the Commission. This in turn will allow the Commission to demonstrate the effectiveness and efficiency of its planning and implementation efforts to its stakeholders and to the general public. Equally important, an effective evaluation program provides critical information to help continually improve the Proposition 10 implementation process in Kern County. This will allow the Commission to continually improve its efforts to better the health and well-being of children and families in Kern County.

EVALUATION COMPONENTS

The evaluation program will have a number of components designed to obtain objective information about key aspects of program implementation and impact. The evaluation program will describe and measure the correlation between program and service design, program and service delivery and the goals, outcomes, and performance measures described in this Strategic Plan. The evaluation program will provide a systematic manner in which to manage data collection and presentation in a timely and effective manner. The evaluation program will depend upon data provided by the program or service provider and upon data obtained from other sources.

The evaluation program will be based upon the goals, outcomes, performance measures, and indicators outlined in the Strategic Plan. It will provide evidence of the impact of participation in supported programs using child and family outcomes described in the Plan. Specifically, it will provide evidence about the overall effectiveness and performance of the overall Plan and of its individual strategic elements. Further, it will offer information about the magnitude of Commission-sponsored program impacts on child and family outcomes in terms that may be understood by the educated lay public, using reliable and valid, outcome measures.

The evaluation program will measure program and service performance. Specifically, the evaluation will provide data on the quality and quantity of programs and services supported by the Commission. Measurement of program costs and benefits will be included. The evaluation program will be designed to function as an integral part of the Commission's program and will be the basis of such items as periodic reports to program personnel and key decision-makers, regular staff evaluation activities and annual evaluation reports to the Commission.

TASKS

A number of tasks will be performed in the creation and implementation of a systematic evaluation program. These would include:

- development of a detailed action plan and timeline
- incorporation of evaluation activities into overall program implementation
- assignment and training of staff to oversee evaluation activities and coordinate evaluation and program components
- training of staff in data collection and evaluation methodology and procedures
- establishment of regular reporting formats and schedules between staff, program and service providers and decision-makers

Effective and thorough evaluation methodology, data collection and support will help ensure that the Commission has timely, complete and accurate information to use in evaluating the rate of progress toward strategic goals, the effectiveness of individual providers and services, and the identification of met and unmet needs. As the Commission's work proceeds, staff will work to ensure that a systematic and cost-effective evaluation program is designed and implemented.

VIII. CONCLUSION

Child development research has shown that the quality of a child's life during the early formative years is a critical determinant of the quality of the child's future (e.g., his or her role in society- and his or her contributions to society as an adult). Parents, community members, and service providers have the opportunity to significantly impact children's lives. Whether it is through the use and distribution of appropriate information (e.g., education materials), the development of adequate intervention programs, or the improvement of existing services through better coordination, we as a community recognize that we have an opportunity to make positive contributions to the lives of Kern County's children prenatal to five.

The California Children and Families Act seeks to help provide, on a community-by-community basis, all children prenatal to five years of age with a comprehensive integrated system of early childhood development services. This document describes the framework that the Kern County Children and Families Commission will use to support programs and services that will have significant impact on the outcomes of our children in Kern County. These programs and services are divided into three major focus areas: health and wellness, childcare and early childhood education, parent education and support services. Integration of services and efficient data collection is critical for successful implementation of strategies in these three focus areas. Therefore, additional strategies in these two areas are important to successfully integrate services and provide the necessary data across each focus area .

We realize that the strategic plan embodied by this document is an ambitious one. However, it is by no means to be viewed as a permanent document. It must be seen as the first of many planning and evaluation steps in developing the best objectives, strategies and indicators of success for our children. To improve results, there will be continual refinements to the strategies and indicators. We will also continue to seek input from the community, from families, and from service providers to ensure that we are meeting the children's needs and that service delivery is consistent with our overall goals. This input will be become especially important during the yearly modification of the plan when our objectives, strategies, and indicators will be revisited.

The California Children and Families Act is certainly not the answer to all questions nor the solution for all problems relating to early childhood development. It is, however, our greatest

present instrument for realizing the promise of Proposition 10—that through collaboration and the integration of services, all Kern County children are born and thrive in supportive, safe and loving homes and neighborhoods and they enter school healthy and ready to learn, and become productive, well-adjusted members of society.

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Healthy Mothers, Healthy Babies of Kern County
Healthy Start Family Resource Center
Hospital Council of Northern and Central California
Independent Living Center of Kern County
Jason's Retreat
Kern Child Abuse Prevention Council
Kern County Administrative Office
Kern County Auditor-Controller
Kern County Board of Supervisors
Kern County Child and Family Service
Kern County Child Care Council
Kern County Clerk of the Board
Kern County Collaborative
Kern County Department of Human Services
Kern County Department of Public Health
Kern County District Attorney's Office
Kern County Early Start
Kern County Economic Opportunity Corp.
Kern County General Services
Kern County Information Technology Services
Kern County Library
Kern County Mental Health Department
Kern County Network for Children
Kern County Office of County Counsel
Kern County Personnel Department
Kern County Probation Department
Kern County Superintendent of Schools
Kern County Treasurer-Tax Collector
Kern County Youth Mariachi Foundation
Kern Family Health Care Plan
Kern Government Television (KGOV)
Kern Regional Center
Kern River Valley Collaborative
Kernville Union School District
Lamont School District
Lamont/Weedpatch Neighborhood Partnership
Little Deer Family Child Care
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